Findings and
Recommendations

Medicaid Eligibility Determination Process

December 16, 2004

Legislative Program Review
& Investigations Committee

Connecticut General Assembly

Introduction

In 2004, the program review committee authorized a study of the Department of Social Services' (DSS) implementation of the application and eligibility determination process for the Medicaid program. The study request was prompted by concerns that applications were taking too long to process, and that delays might be affecting client access to Medicaid. Specifically, the study was to determine how state employee layoffs, early retirements and DSS restructuring have impacted the administration of eligibility determination for the program.

The staff briefing report issued in September 2004 described many of the programmatic aspects of Medicaid, including federal and state laws, regulations, and other requirements regarding Medicaid eligibility determination, as well as standards for timeliness and accuracy of determination decisions.

The briefing report indicated that while there are specific time requirements established in federal regulation for determining Medicaid eligibility, the Center for Medicaid and Medicare Services (CMS), the federal administering agency, requires no reporting on timeliness. Thus, seldom are sanctions imposed on states for deficiencies in timeliness, as they are when high Medicaid error rates for eligibility are incurred.

The briefing report described the processes and systems used by DSS to determine eligibility, including accepting applications, collecting and verifying eligibility information, determining and redetermining eligibility for the major Medicaid populations. The major management and oversight mechanisms in place were also described.

Also, analysis on the statewide trends in Medicaid caseloads and applications by population was provided in the briefing report. Specifically, the report addressed overdue applications, including the percentage of overdue "unexcused" (meaning DSS is responsible for lateness) --a standard DSS must meet to be in compliance with a legal stipulated agreement, known as the Alvarez agreement.

This staff findings and recommendations report contains four sections. The first section discusses application processing, and builds upon the analysis and preliminary findings in the briefing materials. This section also provides detailed analysis of differences among offices in the processing times and denial rates of new family Medicaid applications, and examines the issue of overdue redeterminations (i.e. renewals) statewide.

The report concludes that there are substantial variations among offices in the timeliness of application processing. While there is a strong correlation between staffing level reductions and percentages of overdue applications, that does not appear to be the sole factor causing office variation. The committee concludes that, in addition to such quantitative factors, DSS management must also examine other qualitative elements to determine what contributes to office variations in performance and service.

Section Two examines the impact state employee layoffs and early retirements had on DSS, and specifically the eligibility worker classes. The committee believes DSS has been harder hit by staffing reductions than many state agencies and recommends that many of the eligibility worker positions lost to early retirement be restored.

Section Three examines some of the different eligibility options and determination methods employed with various family Medicaid groups. Specifically, the state's experience with options like presumptive eligibility for pregnant women, presumptive eligibility for children, and continuous eligibility for children are addressed. Staff recommends the statutes and policy regarding eligibility for pregnant women be revised, and that presumptive eligibility for children be re-established. This section also discusses some of the issues with long-term care and recommends DSS seek official CMS modifications to the processing of new applications and renewals in that program.

The third section discusses the SCHIP program, the state's supplementary program for children who do not qualify for Medicaid. The section finds that processing time standards are inadequately defined in the contract, and thus it is difficult to measure the contractor's performance in terms of timely processing or referral. The section also discusses other deficiencies with the contract for SCHIP administration and proposes the contract be rewritten and new proposals sought.

Section Four discusses operations and support issues, including proposing that DSS begin work on a long-term plan to upgrade the department's automated eligibility management system, and provide online application capability for HUSKY (i.e., the streamlined enrollment process for family Medicaid) by July 2006. The report concludes that DSS Central Operations should take more of a leadership role and a "quality management" approach in ensuring the district offices receive adequate support services to fulfill their charge to provide efficient and effective client services.

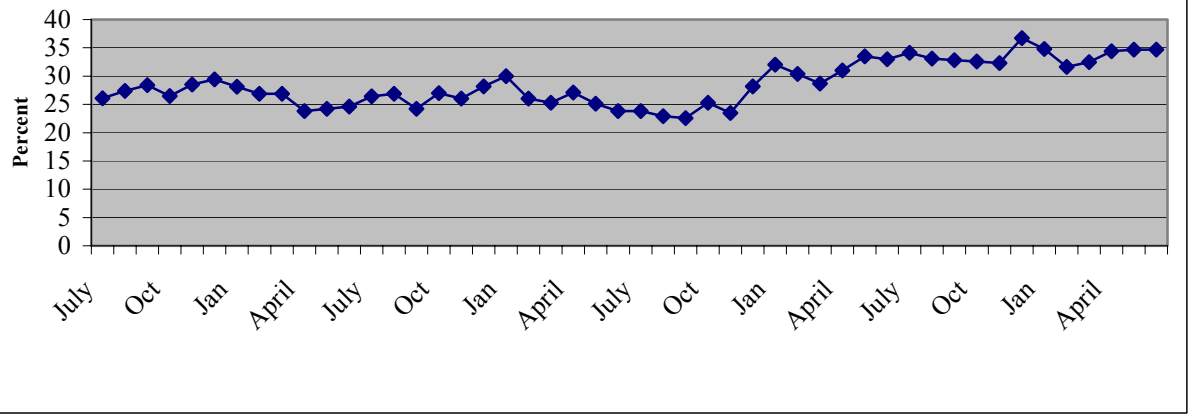
Section 1: Application Processing

Overdue Applications

Federal regulations require that eligibility for Medicaid be determined by the designated state agency (i.e., Department of Social Services) within a certain time period, known as the standard of promptness (SOP). The SOP is typically 45 days for most Medicaid applications, and 90 days if the client must establish a disability in order to become eligible. Extensions may be granted to applicants in order to obtain documents, or fulfill other requirements to establish eligibility.

Figure I-1 shows the percent of pending applications overdue beyond the SOP for Medicaid in Connecticut has been increasing. From FY 01 through FY 04 the percentage of all pending Medicaid applications that are overdue each month has increased from about 27 percent to 34 percent.

Figure I -1. Percent of Pending Applications Overdue Each Month FY 01-FY 04



The extent of the problem of overdue applications varies considerably among the different Medicaid populations:

- pending long-term care applications that are overdue increased from 55 percent in FY 01, to 60 percent in FY 04;
- pending applications for the aged, blind or disabled Medicaid population that are overdue (beyond 90 days) increased from a monthly average of 23 percent in FY 01, to 28 percent in FY 04; and
- pending family Medicaid applications that are overdue each month increased from an average of 10 percent to 16 percent during the FY 01 to FY 04 period.

Specific findings and recommendations for each of the Medicaid populations are discussed later in this report.

Office variation. Because family Medicaid accounts for the bulk of applications for the program, the committee's staff limited its examination of DSS district office application processing to family Medicaid. Committee staff first examined the overdue family Medicaid applications and found considerable variation. Analysis of new family applications for Medicaid is depicted in Table I-1, and results show the following:

- The range in percentages of overdue family applications among offices has grown from 6 to 16 percent in FY 01, to a spread of 3 to 38 percent in FY 04, which indicates a real variation in processing timeliness among offices.

- Increasing caseloads and decreasing staffing levels as documented in the committee staff's briefing report have had varying impact on application processing. Five offices – Hartford, Bridgeport, Danbury, Norwich and New Haven – have experienced increased percentages of overdue family applications between FY 03 and FY 04. Middletown, Stamford, New Britain and Torrington have seen a decrease in percentage of overdue applications in FY 04, while Manchester and Waterbury remained virtually unchanged.

Table I-1 Percentage of Family Medicaid Applications Overdue (Avg. Monthly) FY 01- FY 04

	FY 01	FY 02	FY 03	FY 04
Hartford	10	12	16	38
Manchester	14	15	14	14
New Britain	11	13	18	13
New Haven	9	7	5	6
Middletown	7	8	7	5
Bridgeport	6	8	11	16
Stamford	16	13	19	17
Norwich	11	11	16	29
Danbury	9	7	9	11
Waterbury	10	9	6	6
Torrington	9	5	4	3
Statewide	10	10	13	16

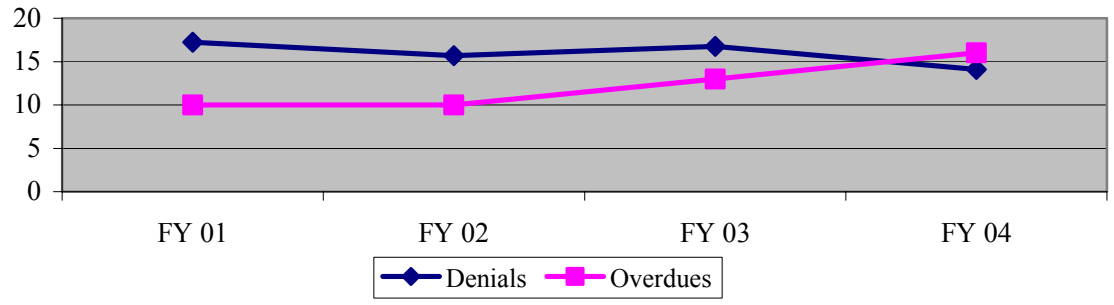
Source: LPR&IC Staff Analysis of Overdue Applications

To explain why some offices have been able to maintain, or even improve, the timeliness of processing Medicaid applications, program review compared several factors including:

- office application denial rates to percentage of overdue applications for family Medicaid;
- recent staffing losses by office, primarily due to early retirements and layoffs;
- office staffing to Medicaid caseloads ratios; and
- current ratio of supervisors to eligibility workers in each of the offices.

Denial rates and overdues. First, committee staff examined the statewide trend in denials of family Medicaid applications to assess whether denial rates had increased as a way to deal with the overdue applications. The results are shown in Figure I-2, and indicate the trend in yearly denial rates decreased about three percent, while the yearly rate of overdue applications increased about six percent over the FY 01- FY 04 period.

Figure I-2. Percentage of Denials and Percentage of Overdue Applications (Family Medicaid) Statewide: FY 01- FY 04



While the variation in eligibility denials among the offices is substantial, as shown in Table I-2, none of the offices appear to be increasing denial rates as a way of addressing overdue applications. Offices that have a higher denial rate than the statewide average in FY 04 (e.g., Stamford, Danbury) have typically denied a higher percentage throughout the four-year period. In fact, in many offices, the average monthly percentage of denials has declined over the four years examined.

Office variation. Some of the variation in denial rates by office can perhaps be explained by *the differences in populations served.* For example, it is plausible that Stamford and Danbury deny more applicants than other offices because their clients do not meet eligibility requirements, like income. However, it is more difficult to explain why fairly substantial differences in denial rates exist when comparing offices like Hartford with New Haven or Bridgeport, since those offices serve similar populations. *The committee was unable to pinpoint reasons for variations since DSS does not track reasons for denials, nor could program review determine if some offices issued more extensions than other offices prior to issuing an award or denial.*

Table I-2. Percentage of Family Medicaid Applications Denied By Office: FY 01 –FY 04

	FY 01	FY 02	FY 03	FY 04
Statewide Avg.	17	16	17	14
Hartford	12	11	12	10
Manchester	18	16	17	11
New Britain	11	9	12	9
New Haven	18	14	16	18
Middletown	15	14	16	13
Bridgeport	18	15	17	18
Stamford	38	31	30	26
Norwich	13	11	10	10
Danbury	22	21	22	21
Waterbury	22	16	14	13
Torrington	13	10	10	11
Central office	9	19	27	8

Source: LPR&IC Staff Analysis of DSS Application Data

Analysis of overdue applications and denials by office indicates that, generally, *DSS locations with consistently high denial rates do not have as high a percentage of overdue applications as those offices with lower denial rates.* For example, New Haven has had a higher than average denial rate over the four-year period, but a fairly low percentage of overdue family Medicaid applications. Harford and Norwich, on the other hand, have had lower than average denial rates, but both offices have had increasing percentages of overdue applications. (A graphic depiction of each office's denial and overdue ratios is contained in Appendix A) The committee *believes this analysis suggests that denial rates are historical by office, and again do not indicate an increasing statewide trend in denials in an effort to lower the backlog of overdue applications.*

Staffing loss impact. Since July 2002, eligibility worker staffing levels have been reduced about 25 percent statewide, while caseloads have increased. This has resulted in a per-staff workload increase of 40 percent, and certainly has been one of the contributing factors in the increasing percentages of overdue applications. Beginning in early 2004, DSS has attempted to redistribute the staff through an "equalization" effort, described in the committee staff's briefing report.

Committee staff examined whether the equalization initiative has been successful by comparing the office-to-statewide staffing ratio for each office to each office's Medicaid cases (assistance units) as a percent of the total Medicaid cases statewide. The staffing data include the three eligibility worker classes – worker, specialist, and supervisor – for FYs 03 and 04. The results are shown in Table I-3.

Table I-3. Medicaid Cases and Staffing By Office
Percent of Statewide Totals (average monthly) FY 03 – FY 04

	FY 03		FY 04	
	% Cases	% Staffing	% Cases	% Staffing
Hartford	16	18	16	17
Manchester	7	7	7	7
New Britain	6	6	7	8
New Haven*	18	21	20	19
Middletown	3	4	4	5
Bridgeport	12	13	13	14
Stamford	4	4	4	4
Norwich*	10	8	9	8
Danbury	3	3	4	4
Waterbury	9	10	9	10
Torrington	3	2	3	3

*Norwich and New Haven had dramatic reductions in caseloads late in FY 04. About 10,000 cases were switched from Norwich to Willimantic (which reopened part time in Feb/March of 2004. About 7,000 cases were transferred from New Haven to Middletown in June of FY 04.

Source: LPR&IC Staff Analysis of DSS Application Data

The table shows that in FY 04, no more than a one percent difference exists between office staffing and Medicaid caseload, as percentages of the statewide totals. *Based on this, program review finds that eligibility staffing to Medicaid caseload ratios by office is evenly distributed. Thus, imbalances in staffing by offices should not be a contributing factor in one office having a higher percentage of overdue applications than another.*

Staffing reductions. *The committee concludes that DSS has succeeded in fairly equalizing staffing levels among offices to match Medicaid caseload.* However, some offices have experienced greater actual reductions in staffing than others. Committee staff analyzed the percentage reduction in staffing by office compared with the percentage of overdue applications. The results are shown in Table I-4.

Committee staff correlated the percentage change in staffing with the percentage change in overdue applications and, as might be expected, there is a significant relationship between staffing reductions and overdue applications by office.

Table I-4. Comparison of Staffing Changes and Percent of Applications Overdue: Average Monthly: FY 03 and FY 04

	FY 03	FY 04		FY 03	FY 04	
	Avg. Monthly Staffing		% Change	% Applications Overdue		%Change
Hartford	139	111	-20%	16	38	+137%
Manchester	52	46	-12%	14	14	0%
New Britain	42	50	+17%	18	13	-28%
New Haven	159	122	-23%	5	6	+20%
Middletown	30	31	+2%	7	5	-28%
Bridgeport	97	90	-8%	11	16	+45%
Stamford	28	23	-15%	19	17	-10%
Norwich	63	54	-14%	16	29	+81%
Danbury	24	23	-6%	9	11	+22%
Waterbury	78	65	-17%	6	6	0%
Torrington	15	16	+5%	4	3	-25%

Source: LPR&IC Staff Analysis of Overdue Applications

However, program review does not believe it is the total contributing factor to overdue applications. For example, staffing reductions alone cannot explain the experiences with overdue applications in Hartford compared to New Haven. In Hartford, overdue application percentage more than doubling from FY 03 to FY 04 -- the greatest increase by far of any office – while its staffing reduction was 20 percent. New Haven's staffing was cut 23 percent, yet New Haven's overdue rate increased by only 20 percent. Further, Stamford had its staffing reduced by 15 percent, yet managed to lower its overdue application rate by 10 percent.

New applications. As a possible explanation for Hartford's increasing overdue problem, committee staff examined the number of new applications for family Medicaid received each month during FY 04 in Hartford and New Haven to compare workload. *The results show that New Haven received a greater number of applications in every month of FY 04. The number of new applications New Haven received averaged 1,412 per month, while Hartford's monthly average was 1,037, almost one-third less. Thus, the Hartford office's dramatic increase in overdue applications cannot be explained by a greater or increasing number of new family Medicaid applications.*

New Haven also incurred greater office disruptions during FY 04 than most offices. New Haven temporarily absorbed Meriden's caseload, until those cases were transferred to Middletown. Further, New Haven SAGA -- which previously had been administered at a separate location with staff assigned exclusively to that program -- was absorbed into the New Haven office with the staffing reductions outlined in Table I-4.

Eligibility supervisors. Committee staff examined eligibility supervisor ratios in each of the offices as a potential indicator of timely application processing, speculating that the better-performing offices (with a lower overdue rate) would have had a lower ratio of workers to supervisors.

The results, shown in Table I-5, include the supervisor-to-worker ratio as well as the percent change in overdue applications between FY 03 and FY 04. The ratio of supervisors to workers is very close among all the offices, except Torrington. In that office, the ratio was more than double the statewide average, yet Torrington has managed to decrease its overdue family Medicaid applications by 25 percent. Further, New Haven and Norwich have the same ratios, yet the increase in percentages of overdue applications was very different. *Thus, in FY 04 the number of workers a supervisor must oversee does not appear to greatly contribute to the overdue application problem. However, the change in supervisor ratios from FY 03 to FY 04, as the change in staffing overall, may be a factor.*

Table I-5. Comparison of Supervisor-to-Worker Ratio By Office: FY 03 and FY 04

	FY 03	FY 04	FY 03 to FY 04 % Increase in Overdue Apps
Statewide Avg.	1 to 8.5	1 to 8.6	
Hartford	1 to 7	1 to 9	+137%
Manchester	1 to 7	1 to 8	0%
New Britain	1 to 7	1 to 8	-28%
New Haven	1 to 12	1 to 10	+20%
Middletown	1 to 10	1 to 9	-28%
Bridgeport	1 to 7	1 to 8	+45%
Stamford	1 to 6	1 to 7	-10%
Norwich	1 to 10	1 to 10	+81%
Danbury	1 to 12	1 to 11	+22%
Waterbury	1 to 8	1 to 7	0%
Torrington	1 to 17	1 to 18	-25%

Source: LPR&IC Staff Analysis of DSS Staffing

The committee believes the overall staffing reductions are significantly related to the increases in overdue applications. However, varying office experiences suggest it is not the sole factor, and other reasons may be ones that are not readily quantifiable. This suggests that issues of performance will not entirely be addressed by increasing staffing, or even supervisory levels, alone. The department must explore further those qualitative issues that foster good performance in some offices, despite staffing cuts and increasing caseloads, while other offices appear less able to manage application backlogs.

Redeterminations

The focus of the committee's briefing report, and the analysis above, has been on the processing of new applications. However, the Department of Social Services must also periodically determine whether clients continue to be eligible for Medicaid, typically every 12 months.

Process. The department's automated eligibility management system (EMS) generates a notice to a Medicaid client about 75 days prior to the client's 12-month expiration date. The notice is sent automatically by the system with the client's eligibility information. The client must verify that nothing has changed with the information, and send the information back to the client's case manager. The client can renew Medicaid eligibility by mail; he or she does not need to come to a DSS office.

The renewal information is supposed to be received by DSS 30 days after the notice is sent. If the information is not returned, and a renewal action is not entered into the EMS system by the caseworker, the system will generate a second notice to the client that the information has not been received and includes the benefit termination date. If needed, a third, final notice is sent two days prior to the termination date telling the client he/she is discontinued. However, the client, in effect, can be reinstated during a 10-day grace period following the termination date, without filing a new application.[1]

In addition, if eligibility has not been reestablished by the end of the redetermination period, DSS continues to provide Medicaid if it appears the client(s) will remain eligible if: 1) DSS is responsible for not completing the redetermination, or 2) the client has good cause, such as illness or other circumstances beyond the client's control. The caseworker enters a continuance code in the EMS system for that circumstance.

Redetermination activity. Figure I-3 shows Medicaid redetermination activity statewide for FYs 01 through 04, including the total for all programs and those for Family Medicaid. As the figure shows, the Family redeterminations generally track the total renewals over the period, and account for about half of all renewals.

As Figure I-3 shows, from January to March 2003, DSS suspended the issuance of renewals while the department closed offices and reduced and transferred staff. When the department resumed the redetermination process, the number of renewals spiked to more than 20,000 per month from April to June 2003.

[1] The department is currently modifying its notification process for redeterminations, in response to concerns raised by legal and client advocates. For example, the second notice will inform the client benefits will be terminated in 10 days if the process is not completed. The third notice—the discontinuance – will no longer be issued.

Figure I-3. Number of Rederminations Per Month Total and Family: FY 01- FY 04

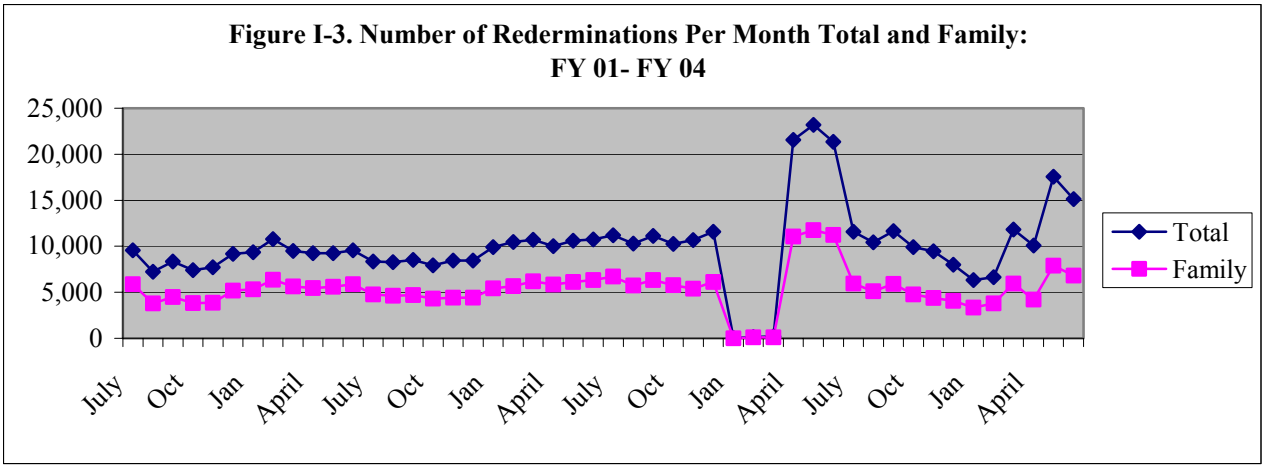
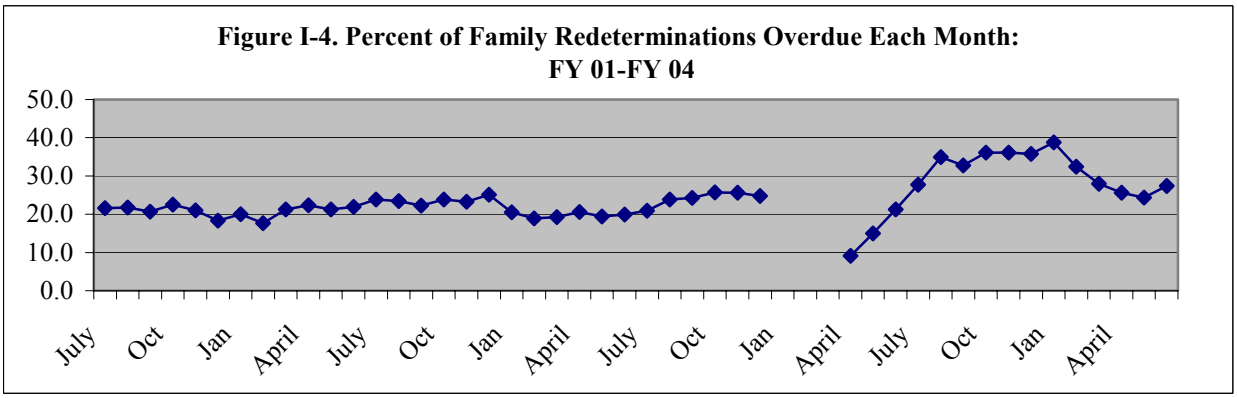


Figure I-4 shows the percent of family Medicaid redeterminations overdue each month. Prior to the office closings and staff reductions, the percentage was typically between 20 to 25 percent. Following the resumption of redetermination processing in April 2003, the first few months had low overdue percentages, due to a lapse in issuing renewal notices. Between August 2003 and January 2004, the overdue renewals increased to between 35 and 40 percent, before declining to the more typical 25 percent level seen in previous months. (The period of renewal suspension appears as a break in the line in Figure I-4.)

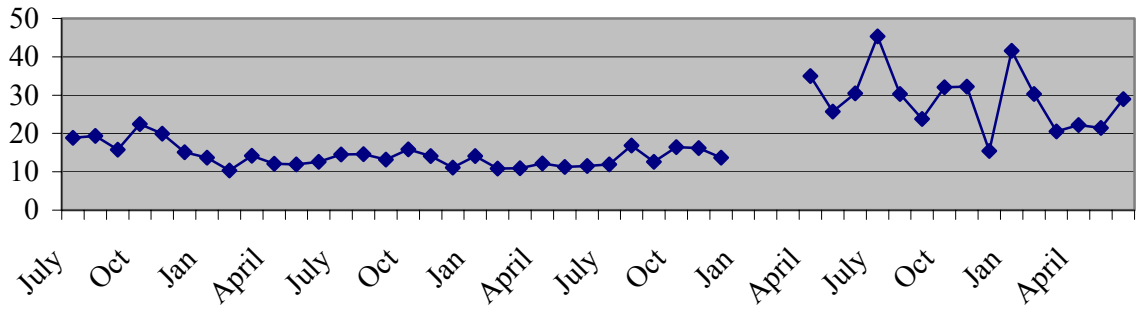
Figure I-4. Percent of Family Redeterminations Overdue Each Month: FY 01-FY 04



Unlike with new applications, when renewals are overdue, the client remains eligible as long as the worker continues the case. However, this could mean that Medicaid payments are made during that overdue period for clients who later are determined ineligible. DSS does not have data to track how many clients with overdue renewals are later found ineligible.

Automatic discontinuance. One of the actions that can be taken in a redetermination case is that the system automatically discontinues the case because the client has not complied with the procedures to continue eligibility, most often not returning the renewal information as required. Figure I-5 shows the percentage of automatic discontinues for family cases during FYs 01-04. Typically, automatic discontinuances had been steadily fewer than 15 percent of redetermination cases prior to January 2003. However, as the figure shows, once renewal issuances resumed in April 2003, the automatic discontinuances became much more erratic, and were generally more than 25 percent of redeterminations issued each month.

Figure I-5. Percent Auto-Discontinued at Redetermination
FY 01- FY 04



DSS provided a partial explanation for the increase in automatic discontinuances. Connecticut had a federal waiver that automatically placed families that did not submit the renewal information -- but whose increased income otherwise qualified them for a two-year Medicaid extension – into that designated coverage group. That waiver ended in 2001, and since then there has been a gradual transition to automatically discontinuing families that do not submit the renewal information to qualify for the earning extension.

The committee believes another contributing factor is that, given the increasing workloads and staff reductions, eligibility staff are less likely to extend a case where the client has not completed the process necessary to redetermine the case. Without a worker's intervention to continue a case, EMS will automatically discontinue the case at the end of the redetermination period.

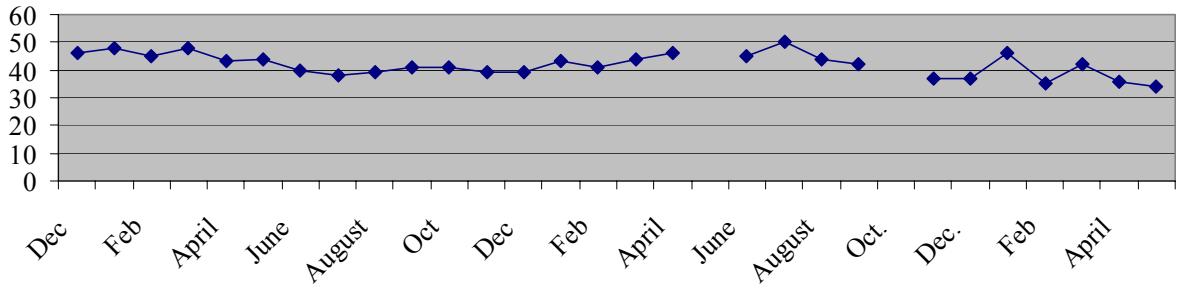
Further, once a worker continues a case, it is up to the worker to track the client's information to ensure it comes in; otherwise, the system continues the client as eligible indefinitely. At the same time, the system recognizes the redetermination as overdue. The more redetermination cases a worker extends without taking an eligibility action, the greater the cumulative percentage of redetermination cases that are overdue, as shown in Figure I-4.

Return to system. The automatic discontinuances can substantially reduce a caseworker's workload, with the EMS automatically taking the actions to discontinue a case when client does not return the renewal information. However, not all automatic discontinuances remain discontinued cases. If the client gets the information to the worker within

10 days after the final date of the redetermination, the case is reinstated without the client having to file a new application. If the client returns after the 10 days, a new application must be filed, and eligibility must be determined based on the information from the new application. Reinstatements and new applications create additional steps for the caseworker that could have been avoided had the client renewed before benefits terminated.

A client's' return to the system the following month is not unusual. The percentage of cases that come back the month after being discontinued is tracked in Figure I-6. The figures shows between 40 to 50 percent of clients return to the system, within one month after an automatic discontinuance, although the last few months appear to be somewhat lower.

Figure I-6. Percentage of Auto-Discontinuances in System the Following Month: Family Cases Dec. 2001- May 2004



Further, these data only capture cases that return *the following month* after being automatically discontinued at redetermination. If the data on returning cases were tracked for a number of months, the percentage returning would likely be even higher.

Recommendations

The committee believes there needs to be more proactive steps taken before a redetermination case becomes overdue or is automatically discontinued, especially given the high percentage of cases that come back into the system the following month. The department is already working on some measures, while others need to be initiated.

Notices and Forms. DSS has been working with a consultant to revise some of its forms and notices. The committee believes, while probably all its notices should be examined, **DSS should first assess which notices are the most problematic in terms of creating client confusion and have the greatest impact on their eligibility.**

The department is planning to eliminate the last notice in the redetermination process –the termination. Instead, DSS plans to send the last reminder – with the termination date included – 10 days before termination. **The committee recommends that DSS proceed with its modifications to the redetermination issuance process. Staff also recommends the redermination forms be modified. These notices to the client should be more concise, with**

the date of return clearly indicated – not in the same type and size text as the body of the letter.

Time management. The DSS training unit has already begun to work with supervisors and workers on "time management" and "priority setting". These elements can be as important in workers efficiently and effectively processing applications as their knowledge of program policy and procedures. However, most training is not mandatory, and workers cannot be evaluated on participation in training.

The committee recommends where possible, supervisors and trainers bring that type of training directly to the workers, especially those who need it, as part of the everyday work experience. DSS should also help workers prioritize their work, which might include color-coding redetermination envelopes by month so that workers can act on the ones about to terminate first.

The EMS-generated "worker alerts", which internally inform the worker about information on a client or case also need to be addressed to be of more benefit to a worker's processing and maintaining a case. **DSS should form a work group, with representatives of eligibility workers, supervisors, and the MIS division to identify which worker alerts could be eliminated. The standard should be "helpfulness to the worker", and include only those alerts that, unless acted upon, will impact a client's eligibility.**

Case information. **DSS must ensure workers use all means to keep both case files, including EMS case notes, and client information current. Specific recommendations in this area are discussed in other sections of the report.**

Overdue redeterminations. **Supervisors need to closely monitor all overdue redetermination cases to ensure workers are obtaining the required information in a timely manner, and that redeterminations are not extended indefinitely. Alternatively, if a redetermination case becomes overdue for three consecutive months, the case should be automatically discontinued.**

Management analysis. **DSS Regional Administrators need to explore reasons for office variation in overdue applications and redeterminations, and denial rates. Further, now that DSS efforts at equalizing staff and supervisors among offices have been put in place, agency management should monitor whether these variations continue. DSS management needs to identify the qualitative factors that foster good performance in some offices, and attempt to implement them in all offices. DSS should report on its findings to the Human Services Committee by July 1, 2005.**

Change of Address

Application processing, and assessing clients' continued eligibility, is reliant on maintaining current information about clients, including where they live. Clients are required to notify DSS if any pertinent information, including a change in address, occurs; however, many do not.

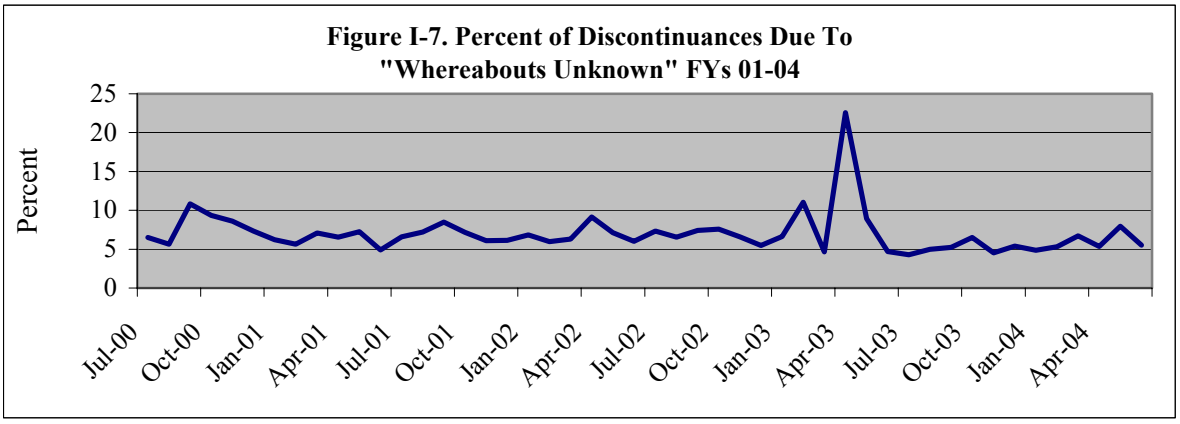
Committee staff visits to DSS district offices revealed the offices experience a large volume of mail returned as "undeliverable." The main reason mail is returned is because it was sent to the address on record but the client was no longer living there.

If a mailing comes back as undeliverable, DSS makes a second attempt to contact a client by mail. If the client cannot be reached, the caseworker will enter a "whereabouts unknown" discontinuance code onto EMS and the client's benefits will be discontinued. Further, a discontinuance for any assistance program the client is on will affect benefits in all programs. For example, if a client's food stamps notice comes back twice as undeliverable, that client will not only be discontinued from food stamps, but any other assistance the client receives, including Medicaid.

Committee staff analyzed monthly EMS discontinuance data for family Medicaid for FYs 01-04 to determine how many clients are discontinued due to "whereabouts unknown" (i.e., address changes). The monthly reports on total discontinuances include households (or assistance units) who are discontinued from one Medicaid coverage group but then transferred to another group due to a change in the client's circumstances. Committee staff excluded these "transfers" from the overall analysis since Medicaid coverage was not actually discontinued.

Figure I-7 shows, over the period analyzed, a monthly average of seven percent of client households had their medical benefits discontinued because their whereabouts could not be determined. Overall, discontinuances due to whereabouts unknown remained relatively constant over the period. However, the dramatic increase in Spring 2003 coincided with the department's suspension, and subsequent resumption of redeterminations and is not indicative of the overall period analyzed.

Figure I-7. Percent of Discontinuances Due To "Whereabouts Unknown" FYs 01-04



As mentioned, clients are required to contact their DSS eligibility worker with any address change, although this is not always done. Instead, clients may contact their managed care organization directly to report changes. Also, at the time of medical service, clients may tell their provider of an address change in response to a standard updating of information requested by providers. The provider may then contact the client's managed care organization regarding the change. Address changes may also come through Affiliate Computer Services – the state's Medicaid managed care enrollment broker.

Several years ago, DSS developed procedures whereby clients would report address changes using a post card system. The system was designed to have the post cards available in different locations (e.g., doctors' offices) so family Medicaid clients could quickly indicate their address changes and send the card back to DSS. The post cards would be sent to the department's central processing unit. The unit, which processed presumptive eligibility applications for children, would then enter any changes onto the department's eligibility management system. The procedures were never implemented because the central processing unit was eliminated due to staff layoffs.

At present, there is no system between either ACS or managed care organizations (MCOs) and DSS – including electronic interface – to exchange client address change information. DSS has been reluctant in the past to allow non-state entities access to its eligibility management system. However, without some type of interface between DSS and either the state's enrollment broker or MCOs, the department may not have the most current addresses for its clients if any changes were reported to either entity and not to DSS.

This issue has been a frequent discussion topic of the Medicaid Managed Care Council's Consumer Access Subcommittee. Program review staff attended subcommittee meetings throughout the year when the address change issue was discussed. At one point, one MCO (Community Health Network (CHN)) was going to try a test project using a post card process whereby clients reporting address changes to the MCO would be sent a post card reminding them to contact their DSS caseworker with the change, but the plan never fully materialized.

The subcommittee was recently presented a proposal by DSS to have the department and CHN develop a pilot program for exchanging address information. The concept being discussed is that CHN, by early 2005, through limited access to various EMS screens, would be able to verify addresses against its records and then electronically transmit any changes through an EMS "alert" directly to the client's DSS eligibility services worker. The caseworker would manually update EMS with the new address. The MCO would then reconcile client information using the next enrollment reports received from DSS (usually within 30-45 days) to see if the change was made. If the worker did not update EMS, a list of client address changes would be sent to the central DSS Family Services division where a worker would update EMS.

At this time, DSS management information systems staff is currently in the process of establishing CHN's access to EMS and testing the applicable EMS screens necessary to begin the project. CHN already has limited access to EMS for its work within the SAGA program, a key reason CHN is being used for the address change pilot program.

Although the test project for the address change interface is being planned to include DSS and an MCO, the committee believes ACS, as the state's Medicaid managed care enrollment broker, should have the interface with DSS and be assigned specific responsibility for ensuring client address changes are made. ACS may be the most effective and efficient source of information given it is responsible for maintaining client information for all enrollees, and not those limited to a particular MCO.

DSS should require, as part of the state's Medicaid managed care enrollment broker contract, that the enrollment broker review its enrollment data and submit address

changes electronically to a central location within DSS, such as the Administrative Services Division. A DSS data processing technician located in the central office should be responsible for regularly updating address changes on the department's eligibility management system. Once the address changes have been made in EMS, all applicable eligibility staff should be notified of the changes.

Rationale. The committee believes the initiative to allow an outside entity limited access to EMS is a positive move toward more efficiently updating address changes. However, a centralized and comprehensive address change process through the state's enrollment broker, rather than the decentralized one being pursued by DSS, is preferable for several reasons. First, eligibility service workers do not need to have their workload increased. Workers currently receive numerous "alerts" through the EMS e-mail system as a way to manage their client workload. The proposed pilot program would have an MCO sending an eligibility worker an e-mail every time an address change occurs for clients within that worker's caseload. Given the number of messages workers currently receive through EMS, address updates sent directly from MCOs may not receive immediate attention from workers and would then be processed by DSS central office staff anyway under the current pilot program.

Second, updating address changes through EMS is strictly an administrative function. Eligibility workers should be relieved of as many extraneous administrative functions as possible, allowing them to focus more on eligibility determination and client service. Since updating addresses is not an eligibility issue, the function should be done by a data processing technician on a centralized basis, similar to the system used by DSS to add newborns onto EMS.

Third, implementation of this recommendation would give the department and the enrollment broker more control than with the decentralized one proposed. Also, communication and coordination would be targeted to DSS and the enrollment broker only, instead of involving multiple MCOs under a decentralized process. Centralization and single responsibility would further increase overall efficiency and effectiveness. It would also help solve DSS' issue with providing too many non-state entities access to EMS.

CHN currently serves about 54,000 of the 307,000 Medicaid and TFA clients enrolled in managed care organizations, or approximately18 percent of all enrollees. CHN receives about 200 address changes per week from its members. Expanding this experience to the entire family Medicaid population, committee staff estimates 5,000 assistance units change addresses per month, which translates roughly to four percent of the family Medicaid assistance units requesting address changes in any given month. Thus, DSS should anticipate receiving about 250 address changes per day once the electronic interface process for address changes is fully implemented.

The committee believes DSS should be able to implement the recommended address change process within existing staff resources. However, if, after six months, the department determines an additional staff person is necessary, it should submit a formal request for additional staff through the budget process.

The committee also believes there should be cost savings associated with a new process. A more efficient process should reduce the number of redetermination forms sent to wrong

addresses, thus lessening the number of new applications submitted by clients who did not contact DSS within the requisite time period and decreasing eligibility workers' time spent to process those new applications.

Section 2: Impact of Staffing Reductions

DSS Staffing Losses

Since the beginning of FY 03, DSS has seen its staff reduced 25 percent agency-wide as a result of layoffs and early retirements as discussed in the briefing report. Assessing whether DSS has taken a deeper cut than most agencies, and whether eligibility workers are especially impacted, is somewhat difficult to determine because of lack of clear comparative data before and after the reduction in the state employees workforce.

Lack of good personnel data is due mainly to a major system change in personnel processing and reporting. CORE-CT, the new uniform, automated system for all agency business functions, was implemented during 2003. CORE-CT includes all personnel functions for most state agencies, including management reporting. The new reporting system is not fully operational yet, and will not match the old reporting. For example, it will not be able to count full-time permanent positions in the same way those numbers were reported before, making comparisons over time somewhat unreliable.

Layoffs. Employee layoffs in late 2002 and early 2003 occurred because some state employee unions would not agree to requests for wage concessions. Thus, the layoffs impacted agencies with more unionized employees more than agencies with fewer collective bargaining units or managers. The most reliable data for these numbers statewide is the state budget. Table II-1 shows some layoff impact comparisons.

Table II-1 State Employee Layoffs – Comparison of Impact

	Total Number of Employees in June 2002	Layoffs	Percent of Workforce Laid off
Statewide	53,179	3,006	5.6%
Dept. of Mental Retardation	5,920	266	4.5%
Dept. of Mental Health and Addiction Services	4,184	250	6%
Dept. of Transportation	3,490	270	7.7%
Dept. of Motor Vehicles	680	101	14.8%
Dept. of Social Services	2,356	245	10.3%

Source: LPR&IC Staff Analysis

As the table shows, state employee positions were reduced 5.6 percent statewide, but the impact on individual agencies varied. DSS incurred slightly more than a 10 percent reduction from layoffs, substantially higher than the statewide percentage, and higher than most other agencies analyzed. The eligibility worker classes were especially hard-hit with layoffs, incurring 116 of the total 245 layoffs (almost half) at DSS.

Early retirements. As noted, the other major impact on staffing levels was the early retirement incentive plan (ERIP), a budget reduction measure implemented from March through June 2003. The committee believes this strategy did not consider fairness or balance in how the reductions were distributed among agencies. First, those eligible to take advantage of ERIP varied among agencies, depending on the age and longevity of the workers. Second, taking the early retirement was not mandatory, but was at the option of the employee. In all, about 10,500 employees were eligible for the program; about half of those eligible staff retired, and again that percentage varied from agency to agency.

Refill rates. The budget reduction from ERIP was expected from two sources. First, not all positions lost to early retirement would be refilled, and second, those positions allowed to be refilled would be refilled at lower salary levels.

The Office of Policy and Management established two ERIP refill rates. For direct care or hazardous duty workers, three of four positions could be refilled; for all other positions, only one in three workers. OPM required agencies to submit plans on how the refills would be implemented. The only other factor considered in the refill rate was if a position was totally federally funded. If so, the position was exempt from the agency's rate. However, if there was only partial federal reimbursement, that position was considered in the overall refill ratio.

Exemptions and agency compliance with ERIP refill rates have varied. Further, it was up to agencies outside the executive branch, or those operating under judicial consent decrees, whether to comply with refill plans or not. According to OPM, certain agencies have not complied.

DSS had 295 employees take early retirement, 96 of them in the eligibility worker classes. DSS was allowed a refill rate of one in three; 207 positions were cancelled agency-wide. *However, only 46 of the cancelled positions were in the eligibility classes -- worker, specialist, and supervisor—meaning in those classes, about 50 positions (one in two) were refilled.*

There are a number of reasons for the higher refill rate among eligibility classes. First, *DSS was allowed to refill some eligibility worker positions lost to ERIP on an emergency basis, before an ERIP plan was submitted to OPM. Second, the vast majority of the refills in the three classes were filled at the worker (i.e., lowest) level. For example, only one specialist position, of the 21 ERIP losses, was refilled at that level, and only two of the 17 supervisor positions lost to ERIP were refilled at that level. Third, while DSS has refilled a higher rate of its eligibility worker positions lost to ERIP (about 1 in 2), it has had to consequently refill fewer in the rest of the department (1 in 5).*

Impact. *The committee concludes that staff reductions were deeper in DSS than the statewide average and in many large state agencies. DSS has refilled many more of its allowed position refills where they have a higher impact on client services – in the eligibility classes-but the department has had to absorb a higher level of lost positions in the rest of the agency.*

The full impact of staff reductions in DSS is difficult to quantify. Staff reductions in the eligibility classes, along with office closings, and worker and client caseload transfers, have led to poor morale, which numbers cannot measure.

The committee also finds staffing reductions have contributed to increasing processing times; statewide, there has been an increase of five percent in overdue applications for all Medicaid programs.

The program review committee believes more of the position cuts due to ERIP should be restored. Greater weight should have been placed on refilling positions that deal directly with clients, as eligibility workers do. If a third refill rate -- in the middle of the two used -- had been established allowing a 2 for 3 refill rate for eligibility workers only, DSS would have been able to refill 64 positions rather than 50. Thus, committee believes the 14 positions recommended below would get the eligibility class to that refill rate.

Further, the program review committee believes that OPM should have considered the federal reimbursement levels in the refill rates it allowed. Since eligibility worker costs are reimbursable at 50 percent, this class should have been allowed a higher refill rate than the original 1 for 3, without impacting the rest of DSS' ratio.

To bring the refill rate for the eligibility classes to a more realistic ratio of 2 for 3, the **committee recommends that 14 positions in the eligibility classes be restored.**

Rationale. The committee does not propose that eligibility worker staffing return to pre-layoff and ERIP levels for two reasons. First, office variations in performance, as discussed previously, indicate staffing levels may not be the entire cause of problems in application processing. Second, the layoffs were part of collective bargaining negotiations. Workers affected made an informed decision recognizing the impact on their employment status and workload if a compromise on wage concessions could not be reached. The committee believes replacement of those positions would circumvent that process.

Cost. Program review estimates the recommended restoration of staff will cost approximately $1 million, half of which should be reimbursable by the federal government. The committee estimates each eligibility worker salary to be about $50,000 (mid-range of the job class of eligibility specialist) plus 40 percent fringe. At $70,000 per position x 14 positions, the total is $980,000.

Outstationed workers. Federal law allows the state Medicaid agency to place workers who can determine eligibility at hospitals and other locations where Medicaid applicants are likely to seek medical services. In FY 02, there were 10 such outstationed workers, who were counted in the overall DSS staffing numbers. Currently, there are eight; the reductions in those staff are included in the analysis above.

DSS is planning to restore some of the outstationed workers, but intends to begin with placing them in nursing homes. These workers would be able to process Medicaid long-term care applications only, which should help reduce the backlog of those applications and decrease the percentage of overdue long-term care cases.

DSS Efforts After Staffing Reductions

The Department of Social Services has initiated other efforts to mitigate the impact of staffing reductions and caseload increases. Some have been more successful than others, and other efforts have just begun so their success is yet undetermined.

Staff equalization. *Overall, DSS' efforts to balance the staffing and caseload have been successful. As shown in the previous section, caseload and staffing ratios of the state totals for FY 04 are less than one percent apart in every district office.*

Dedicated processing time. The committee believes the "*dedicated processing time" initiated in all offices in FY 03 is a necessary and effective strategy in managing greater workloads with fewer resources*. This strategy dedicates two afternoons a week for caseworkers to process applications and make eligibility determinations only, without interruption of phone calls or appointments. This is an efficient and productive way to conduct business -- all eligibility workers are performing this function at the same time and distractions are minimized, allowing all workers to focus solely on processing applications and determining eligibility.

The committee believes, however, the dedicated processing time initiative should have been better communicated. Poor communication by DSS about dedicated processing time left clients, advocacy groups and others with a perception that offices were ***closed*** during that time. As noted in the briefing report, offices are not closed and most transactions can still take place; the caseworker is just not available to the client during those hours.

Perhaps enough time has passed since the initiation of this strategy so that all parties have a clear perception of dedicated processing time and its purpose. However, DSS should continue to provide communication about dedicated processing time, its purpose, and the benefits of quicker eligibility determination to clients. Signs are posted in most offices alerting the public to the dedicated processing times, but are not consistent in their information.

DSS should develop uniform signs in English and Spanish, stating regular hours of operation and dedicated processing times, and that offices are open during processing times, but transactions are limited. The signs should be posted in all the offices, the DSS website, and in any brochures on office and program services.

Reducing office traffic. Many transactions do not require a client to come to the office. For example, Medicaid does not require a face-to-face interview to file an application or have benefits renewed. Clients often need to use public transportation, which can be time-consuming, inconvenient, and costly. Further, unnecessary walk-in traffic at DSS offices can delay regularly scheduled appointments, contribute to waiting room congestion, add to security concerns, and cause client frustration. Every attempt should be made to lessen the necessity for clients to come to a DSS office.

DSS should develop a campaign to promote mailing all applications and other forms to the appropriate office when a face-to-face interview is not required. Simple steps might help, like a cover sheet with the application noting in large text that the application can be mailed, rather than delivered, to a DSS office.

Human Services Infrastructure initiative. Another strategy developed by DSS to lessen the impact of staff reductions and office closures has been what DSS calls the "Human Services Infrastructure" initiative, or HSI. This initiative is a collaborative effort between the department and the community action agencies (CAAs), entities largely funded through federal community service block grant funds. The entire initiative is fairly comprehensive and long-term. However, some of the shorter-term efforts, such as CAAs helping clients with the application processing to lessen the DSS workload, appear to be unsuccessful.

Program review staff obtained samples of the memoranda of understanding (MOU) between DSS district offices and the local CAAs. The agreements call for an HSI liaison to be appointed from each DSS office and CAA. According to committee staff interviews with district office staff, these liaisons have all been appointed.

The MOUs also require the CAAs to: 1) assist customers in completing DSS application forms; 2) collect the required documentation for DSS to determine eligibility; and 3) complete the HSI. referral form, along with the application and documents, and transmit to DSS.

DSS provided program review with aggregate data on the referrals made by the CAAs to DSS offices. Statewide, for the quarter from July 1 to September 30, 2004, the 12 CAAs made 214 referrals to DSS for all assistance programs. Given that DSS receives approximately 14,000 Medicaid applications a month, the 214 referrals represent less than one percent. This confirms what committee staff heard anecdotally when it conducted DSS office visits during the summer and fall. All offices reported extremely low referral activity, and indicated deficiencies in the quality and completeness of applications referred.

DSS district staff believe that, in most instances, clients being served by the CAAs are already receiving DSS services, hence the low referral numbers. Also, federal regulations allow only state or county staff to determine eligibility, so the CAA can only transfer the applications to DSS for eligibility determination. But, if the CAAs are not transferring complete applications, this does not lessen DSS' work or save workers' time. However, the committee tabled recommendations that would have changed the functions in the existing contracts and memoranda of agreements between the Department of Social Services and the community action agencies.

Flexible hours. In October 2004, DSS administration began to allow workers more flexible schedules, resulting from an memorandum of understanding between the state and the union representing eligibility workers. The flexible schedule includes a four-day workweek (Wednesdays off), with extended hours for those four days, or working a five-day workweek, with earlier or later than regular hours of business. Early indications are this might not have been coordinated well with other department operations and may have negative outcomes.

For example, while workers might start at 7:00 a.m., the computer systems are not available to workers until 8:00 a.m. Similarly, computer systems are not available to anyone working after 5:00 p.m. While the MIS division is working on extending the hours of computer operations, it has not yet occurred.

In addition, scheduling flexible work hours for workers adds to the responsibilities of supervisors, who are already supervising more people since layoffs and early retirements. Establishing office-area and functional coverage with fewer workers available during the normal business hours becomes a scheduling and management dilemma. Further, many of the contacts an eligibility worker needs to make – calling for medical records, or calling other agencies, banks, nursing homes – would seem more accessible during regular hours. Workers in the building before and after regular hours may also add to the security issues. The committee believes attempts should be made to maintain good labor relations, but that the ultimate objective to serve clients efficiently and effectively should not be sacrificed either.

Section 3: Eligibility Determination by Program

To be eligible for Medicaid, an individual must meet certain financial criteria and be part of a group that is categorically eligible for the program. However, the criteria for each group, the manner in which the criteria are verified, and who can determine eligibility all vary. These factors all impact the application processing and timeliness of the determination. This section describes and analyzes the application processing and eligibility decisions for several groups in the family Medicaid program, and long-term care.

Presumptive Eligibility for Pregnant Women

Federal law allows states to include in their state Medicaid plans the option of providing ambulatory prenatal care services to pregnant women during a temporary period of presumptive eligibility (PE), as long as the applicant's gross family income does not exceed the applicable income level of eligibility under the state plan.

Presumptive eligibility means that eligibility has not been determined, but is granted on a temporary basis. Federal guidelines allow qualified entities, as defined in law, to determine whether a person is "presumptively" eligible for covered services. Examples of qualified entities include those: 1) eligible for Medicaid payments under the state plan; 2) providing services comparable to outpatient hospitals, rural health clinics, or clinics under the direction of a physician and determined by the state to be capable of making PE determinations; 3) receiving federal funds (e.g., mobile health centers or community health centers); or 4) participating in particular federal supplemental food programs, including schools.

The presumptive eligibility period begins on the date a qualified entity determines the pregnant woman meets the minimum income criterion for presumptive eligibility. PE ends the earlier of: 1) the day full Medicaid eligibility is determined if an application is filed; or 2) the last day of the following month when PE was determined if an application for full Medicaid is not filed.

Qualified entities have five working days after the PE determination date to notify the applicable state agency that presumptive eligibility was granted. Federal law also requires qualified entities to inform the pregnant woman at the time PE is determined that a full application for Medicaid is required no later than the end of the month following in which PE date was determined.

During the PE period, a pregnant woman may receive prenatal ambulatory care services. If a pregnant woman is later determined ineligible for full Medicaid, federal reimbursement is still available for services rendered during the time of presumptive eligibility.

Connecticut Requirements

Connecticut law requires DSS to implement "presumptive eligibility" for pregnant women in accordance with applicable federal law and regulations. However, Connecticut has never included the option of presumptive eligibility, as described above, in its state Medicaid plan. The state law requiring presumptive eligibility determinations for pregnant women went into effect September 1991. At that time, DSS administration decided not to implement the option of presumptive eligibility as outlined in federal law.

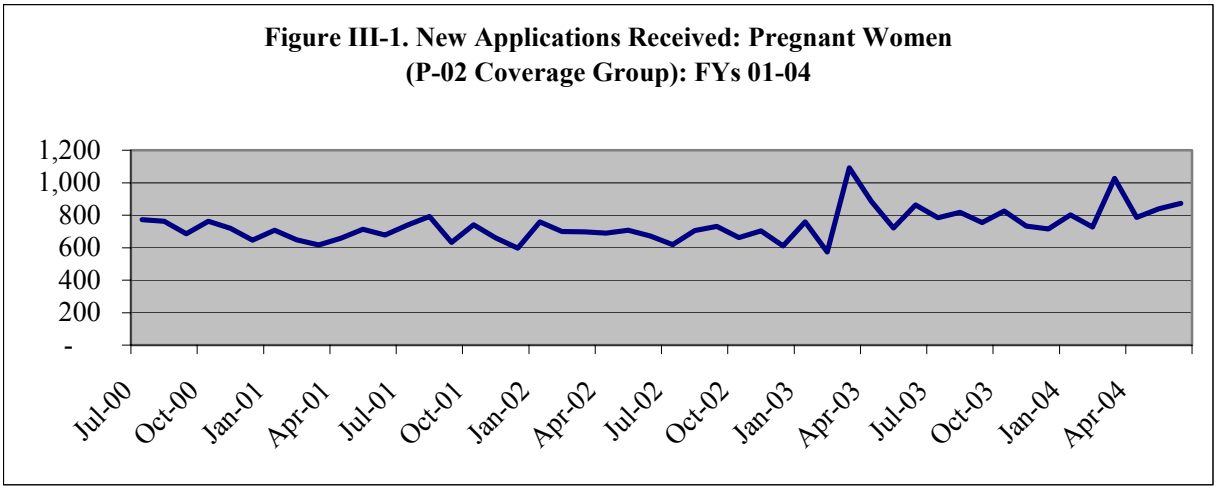
DSS system for processing pregnant women applications. *DSS, through its policies and procedures, implements a system of "expedited eligibility" for pregnant women applying for medical coverage. The DSS system is not based on the federal model of presumptive eligibility.*

DSS policy states pregnant women with incomes not exceeding 185 percent of the federal poverty level must be granted Medicaid benefits within one day from when required minimum information is received. The minimum information includes applicant identity (including citizenship status), proof of pregnancy, and family income. By policy, verification from the applicant is required if the declared income is more than 85 percent of the income limit, even though the department, since 2001, has accepted self-declared statements of income from applicants.

Applicants have 30 days from the date of application to submit all minimum required information. If the minimum information is not received by DSS by the deadline, eligibility is denied. Eligibility determination by DSS must be made no later than the day after receipt of the required minimum information. Once granted, the client is placed in a separate Medicaid coverage group for pregnant women (i.e., P-02).

Application activity. Figure III-1 shows the number of new applications received monthly by DSS under the P-02 coverage group for fiscal years 2001-2004. The department received an average of 737 applications per month during that period. The overall trend of applications received has generally ranged around 700 per month, but increased during FY 04 to roughly 800 applications a month.

Figure III-1. New Applications Received: Pregnant Women (P-02 Coverage Group): FYs 01-04



Committee staff planned to analyze the overall timeliness of processing pregnant woman applications. However, *there is no management report regularly produced by EMS or analyzed by the department showing the length of time taken to process applications for pregnant women, whether processing times are consistent with the department's standard that all minimum required information be submitted within 30 days, or whether eligibility decisions are made within one day from when the minimum information is received.*

DSS created an "ad hoc" report for program review from its eligibility management system showing the length of time taken to process pregnant women applications in October 2004. The department measured the number of days from the date of application to the application disposition date. Table III-1 shows the results.

Table III-1. Pregnant Women Application Processing Times: October 2004*

	Days to Process: From application date to disposition date						
Disposition	**0 to 4**	**5 to 7**	**8 to 10**	**11 to 15**	**16 to 30**	**Over 30**	**Totals**
Granted	156	70	39	51	84	86	486
1. Denied	62	25	12	23	74	160	356
Other**	2	1		2	5	18	28
Totals	220	96	51	76	163	264	870

*P-02 coverage group only.
**Other includes cancelled and withdrawn applications.
Source: LPR&IC Staff Analysis of DSS Data.

Table III-1 shows, of the total 870 dispositions for pregnant women applications in October 2004, 606 dispositions (70 percent) were within the 30-day limit established by DSS for applicants to submit the minimum required information of proof of pregnancy, income, and citizenship status.[2] What cannot be determined from the data, however, is the actual time DSS took to process the applications and whether the one-day processing time policy was followed.

The table also shows dispositions for 264 applicants (30 percent) were made beyond 30 days, meaning either the minimum information was not submitted within the required timeframe or DSS did not process the application on time if the information was submitted within the 30-day limit.

Of the 486 applications *granted* eligibility, 400 (82 percent) were made within 30 days of the application date, meaning the required information was submitted on time. This also indicates the remaining 18 percent of applicants granted eligibility beyond the 30 days, were either given extensions to the expedited eligibility period, which is not provided for in policy, or

[2] The data are only for one month and may not be wholly indicative of processing times over a longer period of time. However, this issue has been under examination since this study began and committee staff believes the timeliness issue would have improved by October 2004.

the proper information was submitted within the 30-day period and DSS took longer than the required one day to grant the case (except those processed by day 31).

Of the 356 applications *denied* eligibility, 196 (55 percent) were denied – based on the application information – within the 30-day limit. The remaining 160 applications (45 percent) were denied eligibility beyond 30 days. Further complicating the denial rates for the P-02 coverage group is the fact that women who do not have legal immigrant status are not eligible for full Medicaid, or even for prenatal care or other services under P-02, but are eligible for the labor and delivery services under P-02 emergency care. Due to the way EMS is designed, the woman would be granted Medicaid for the month her baby was born to cover the medical services provided at that time, but then denied benefits for the following month because she would not meet citizenship requirements to continue Medicaid coverage. The case would be recorded as denied.

Upon further review by DSS, the department concluded the vast majority of denials was due to non-citizens receiving emergency services the prior month and then denied Medicaid in the current month. Given this, the percentage of pregnant women application denials would actually be lower, since women are in fact *granted P-02 eligibility* emergency labor and delivery services in that month and then *denied* under P-02 coverage the following month.

There is no formal policy or procedure directing eligibility workers to send notices to pregnant applicants indicating missing information for eligibility. The central office notes that practices regarding contacting applicants vary among district offices – some offices send notices, while others do not.

In interviews with committee staff, DSS district office managers and supervisors confirmed *timeframes vary as to how quickly applications for pregnant women are processed once the minimum required information is received*, ranging from roughly several days to several weeks. Other offices noted their processing times are within the required one-day turnaround.

The department does not differentiate assistance applications for pregnant women from the regular HUSKY applications it receives. Historically, applications from Healthy Start programs had included a special stamp alerting workers the applications were for pregnant women. This process is no longer used due to the decline in the number of Healthy Start programs. Without a quick way to clearly distinguish applications for pregnant women for expedited processing, the chances increase that such applications could be overlooked during the normal course of business and not processed as quickly as required.

Many DSS policies and procedures for processing pregnant women applications have not been updated since 1991, and at least one important policy – requiring income verification beyond a certain level – is outdated since the department began accepting self-declared statements of income based on federal requirements and does not reflect current practice.

Because of the regional differences in policy implementation, the DSS central office sent written clarification in early 2004 to its regions regarding the department's one-day processing time for applications. According to committee staff interviews with district office managers and

supervisors, and staff analysis of processing times, however, the notification has not worked and "expedited eligibility" is not occurring in many instance for pregnant women applications.

Based on the above analysis, the committee recommends:

- **C.G.S. Sec. 17b-277 should be amended to eliminate presumptive eligibility and require DSS implement a system of "expedited eligibility" determination for pregnant women instead.**

- **DSS uniform policies and procedures should reflect the wording change from "presumptive eligibility" to "expedited eligibility." DSS should also require applications for pregnant women considered non-emergencies be processed within five days once all required information is received from the applicant. All emergency applications should be processed using a one-day standard.**

- **DSS should develop a system (e.g., using a color-coded application/envelope) to clearly identify applications submitted by pregnant women for medical assistance as a way to differentiate such applications from others received by the department.**

- **DSS should begin routinely analyzing the length of time it takes to process applications for pregnant women to ensure applications are processed in accordance with the department's specified policy.**

- **DSS should review all policies and procedures regarding expedited processing of pregnant women applications to ensure they are applicable, coordinated, and understood by eligibility staff. The department should also ensure all appropriate staff are continually kept informed of the department's policies and procedures regarding expedited eligibility for pregnant women, including any changes or updates.**

- **DSS should increase its efforts with outreach workers and other qualified entities to review how to assist clients with completing applications to ensure the necessary information is submitted to DSS allowing quicker eligibility determinations.**

- **DSS should emphasize to providers that complete applications are a key component to determining eligibility and having services covered for payment.**

- **DSS should develop a policy requiring eligibility workers to inform applicants who have not submitted complete applications of any outstanding information required to complete their applications so eligibility decisions can be made promptly.**

Rationale. The committee believes clarification of the "expedited eligibility" for pregnant women policy, emphasis on qualified entities submitting complete applications for their clients, and more proactive steps by DSS prior to denying applications, should ensure more complete applications, a greater percentage of applicants granted eligibility, and an increase in medical coverage for pregnant women.

With regard to processing timeframes, though committee staff did not do a file review to determine processing times among all the district offices, staff believes the recommended five-day determination period provides a more realistic timeframe than the one-day standard in place for offices to process pregnant women applications. The extended period is necessary given variations in current processing times, cuts in the number of eligibility determination workers, and an increase in overall caseloads.

The committee also believes moving to the expedited eligibility determination process is preferable to a system of presumptive eligibility for pregnant women, given the information staff received from the department regarding reasons for the high denial rate occurring in October 2004. As well, assigning presumptive eligibility to entities other than DSS could increase the number of applicants without legal citizenship status receiving Medicaid benefits on a presumptive basis. DSS also indicates full Medicaid benefits are available to pregnant women under the state's expedited eligibility system, whereby only ambulatory prenatal care benefits are available under the federal guidelines for presumptive eligibility.

Newborns

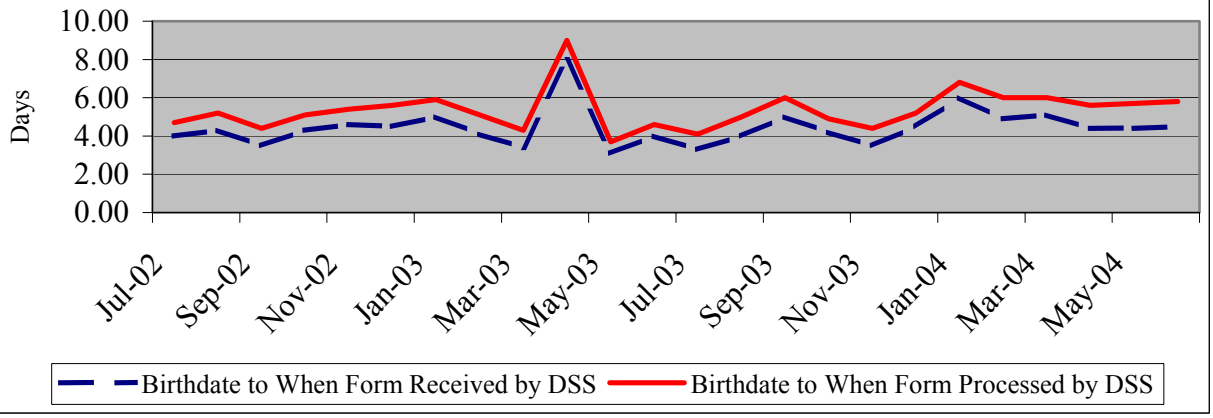
DSS has a centralized process in place to enroll newborns, whereby upon the birth of a child, hospitals have a maximum of five days to fax the required newborn Medicaid request form to a central newborn unit within DSS. DSS processing technicians within the unit are responsible for processing the forms, ensuring the mothers are already receiving assistance through either Medicaid or TANF, and entering the appropriate information onto the department's eligibility management system. The newborn unit cannot grant or deny eligibility, but only add newborn information to the system, which guarantees hospitals payment for the service related to the birth. Further, EMS issues a client identification number for each newborn eligible for Medicaid. The number is put on the form, which is faxed back to the hospital.

If a mother is not already receiving assistance, the central unit notifies the hospital. The unit also sends a weekly list of new mothers not receiving Medicaid to district offices for follow-up by caseworkers. The DSS district office will then send an application to the new mother. If the hospital has an outstationed worker, the worker may initiate the application process for the mother.

A separate database containing relevant information about the newborn application process is maintained by the central unit. The database tracks various factors, including the length of time it takes hospitals to submit the forms and DSS to process them and provide coverage for the newborns. DSS notifies hospitals on a quarterly basis as to how well they are processing newborn forms. More frequent communication occurs if necessary.

Committee staff analyzed the unit's data to determine if there are delays in processing newborn applications and where those delays may occur. Figure III-2 shows: 1) the average length of time all hospitals took to submit the required form to DSS following a birth; and 2) the overall time taken from the date of a child's birth to when the request form is processed by DSS and a client Medicaid number is determined for the child.

Figure III-2 . Average Length of Time to Process Newborn Applications:FYs 2003-2004



As the figure shows, *the amount of time hospitals took to submit newborn Medicaid eligibility forms for FYs 2003 and 2004 averaged 4.4 days. This average is below the unit's required standard of five days.* On average, it then took DSS 0.9 days to process the forms. Thus, the overall process, from date of birth to when DSS processes the newborn application form, averaged 5.4 days for FYs 2003-04. *Therefore, the committee found the process for enrolling newborns on the Medicaid program is performed in a timely manner.*

The figure also shows an increase in early 2003 and again in early 2004 in the time hospitals took to submit the newborn forms. The DSS central newborn unit notes, and committee staff confirmed during is district office visits, that *state layoffs and early retirements, and the elimination of the department's central unit for processing presumptive eligibility for children, caused confusion among some hospitals regarding the process used to file newborn applications and where they should be sent. To lessen the confusion, the newborn unit contacted hospitals to clarify the process. Since early 2004, the time factors highlighted in the above figure have recovered and remained relatively steady.*

Continuous Eligibility for Children

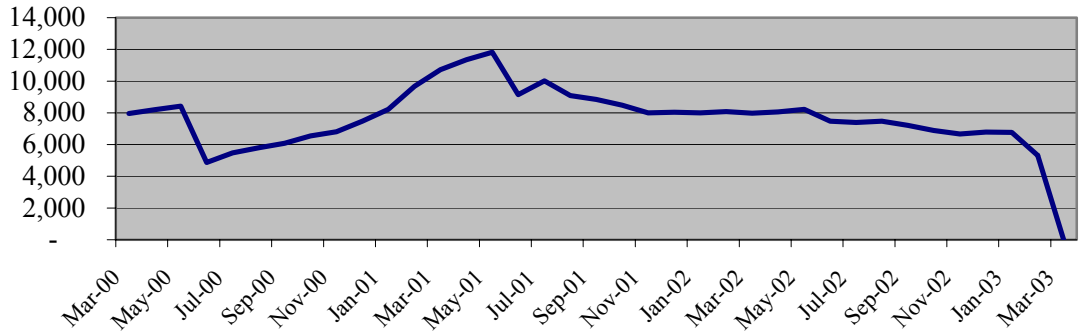
Federal law give states the option in their state Medicaid plan to allow children to retain medical coverage for up to 12 months after their enrollment or renewal, regardless of a change in family circumstances that might affect eligibility. "Continuous eligibility" (CE) was devised to promote continuity of care and assure families, providers, and managed care plans that coverage would be maintained for a predictable period of time.

Connecticut included continuous eligibility as an optional coverage group in its state Medicaid plan effective July 1998. By policy, CE allowed children under age 19 and enrolled in HUSKY to remain eligible for coverage for up to 12 months from the date a child was determined eligible. In practice, the DSS eligibility management system used CE as the last coverage group before a child would be discontinued from HUSKY A.

As a budget reduction measure, the CE program was eliminated by the legislature effective March 2003, with an estimated cost savings of $11.9 million for FYs 04-05.

Continuous eligibility activity. Committee staff examined EMS reports for the continuous eligibility coverage group to identify the total number of children covered. Data for the three-year period from March 2000 through March 2003, when CE was eliminated, were analyzed. Figure III-3 shows the results.

Figure III-3. Continuous Eligiblity Recipients: March 2000-March 2003

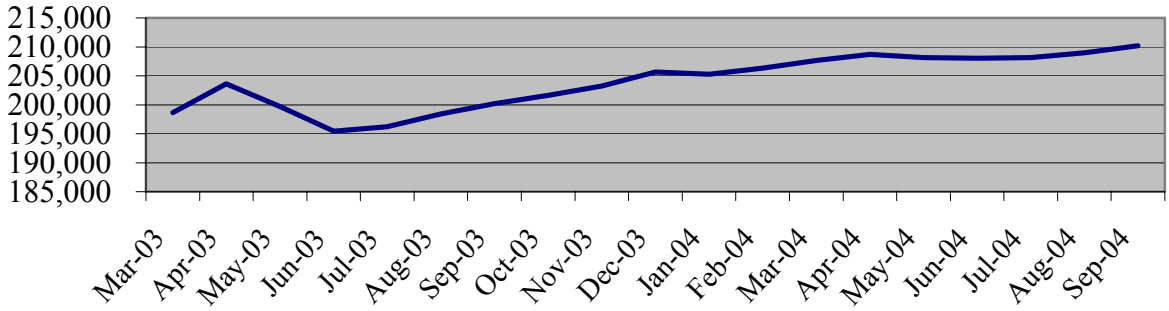


The figure shows the number of children receiving medical benefits under the continuous eligibility coverage group between March 2000 and March 2003 reached a peak of 12,000 children in mid-2001. For the full three-year period, however, the trend of children covered under continuous eligibility gradually declined, and only 5,300 children were receiving medical benefits in February 2003, just prior to when the program ended. *On average, 7,900 children a month received benefits over the time span analyzed. Data for that time period showed children receiving CE each month averaged 4.2 percent of the total HUSKY recipients under age 19.* Since *continuous eligibility was the last coverage group selected for children*, one assumes those children would have lost their coverage except for the existence of continuous eligibility.

Committee staff also examined the total number of HUSKY A recipients (under age 19) to see if there was a decline in recipients following the discontinuation of the CE program. Figure III-4 shows *there was a decline of about 8,200 (4 percent) HUSKY A recipients under age 19 from March 2003 to June 2003, the months immediately following the termination of the continuous eligibility program.* This decline would be expected given 5,300 clients were receiving medical coverage through CE at that time the program ended. However, that decline was short-lived. Beginning in June 2003, the number of HUSKY recipients began steadily increasing through September 2004. *Thus, while it is clear there was a sharp drop in HUSKY*

recipients in the several months immediately following the termination of CE, it is difficult to quantify how many of those children eventually became eligible for HUSKY A at a later time or were enrolled in HUSKY B.

Figure III-4. HUSKY A Recipients (<Age 19) After Termination of CE:
March 2003-September 2004



Presumptive Eligibility for Children

Federal Guidelines

The Balanced Budget Act of 1997 gives states the option under their Medicaid programs to grant assistance to children under 19 using "presumptive eligibility." As with presumptive eligibility for pregnant women under federal guidelines, qualified entities in the community determine whether a child is initially (i.e., presumptively) eligible for Medicaid based on the information supplied by the applicant.

An abbreviated application can be used and children immediately become eligible for Medicaid based on a child's age and family income. A qualified entity has five working days to notify the state agency that a presumptive eligibility determination was made. Entities must also notify the child's parent/custodian that an application for Medicaid is required by the end of the month following the PE decision in order to qualify for continued medical services.

Medicaid coverage during the presumptive eligibility period ends the earlier of: 1) the day on which a decision for Medicaid benefits has been made based on a full application; or 2) the last day of the month following the date when presumptive eligibility was determined if a full Medicaid application has not been received. Under federal guidelines, children are entitled to all Medicaid services during the presumptive eligibility period, and federal reimbursement is provided. If a child is later determined ineligible for Medicaid, federal reimbursement is still provided for services rendered during the time of presumptive eligibility.

Connecticut's Process

Presuming eligibility. *Connecticut law established presumptive eligibility for children in 1997, and inclusion in the state's Medicaid plan was effective October 2000.* Once the option for presumptive eligibility for children was adopted in the state Medicaid plan, Connecticut was required to implement the program according to federal laws and regulations. *The legislature terminated presumptive eligibility for children in August 2003*, and the provision was eliminated from the state plan effective September 2003.

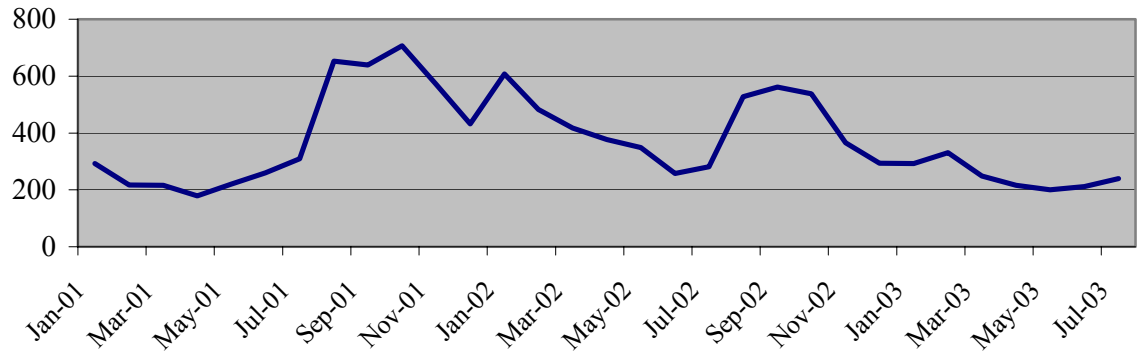
During program operation, all presumptive eligibility applications for children were processed through the department's centralized eligibility processing unit (CPU) and based on self-declared information from the client. Qualified entities had to submit a one-page application form (i.e., fast form) within five days of making the eligibility determination. Clients were given a temporary voucher, good for five days, by the qualified entity at the time of application identifying them as eligible for Medicaid whenever and wherever services were sought.

Once the DSS central processing unit received the one-page presumptive eligibility application, the unit used that information to pre-fill a full Medicaid application. The unit then sent the partially completed application to the client, along with a temporary Medicaid card. The card replaced the voucher and covered clients during the period of presumptive eligibility.

The CPU was disbanded at the end of 2002 as a result of agency layoffs. The department's Fraud and Recovery unit temporarily administered the program from January 2003 until elimination of the program in August 2003.

Figure III-5 shows the number of children who were granted presumptive eligibility from January 2001 through July 2003. The data were derived from monthly tracking reports specifically kept by the central PE unit and by EMS for the months following the unit's elimination. The figure shows *the number of children granted PE during the period analyzed fluctuated between 200 and 800 a month, with an overall gradual decline in cases granted. The monthly average of presumptive eligibility cases granted was 371.*

Figure III-5. Children Granted Presumptive Eligibility: January 2001 - December 2002



Determining full eligibility. Once a case was granted presumptive eligibility, it was incumbent upon the applicant to complete a full application for Medicaid before the period of presumptive eligibility ended. A problem identified with presumptive eligibility for children, and testified to by DSS before the appropriations committee last year, was the high percentage of clients who were subsequently denied HUSKY A coverage mainly because they did not complete the full application process prior to the end of the presumptive eligibility period. This included clients who did not return the full application for Medicaid mailed to them by the CPU, or who did not submit required verification of information.

Committee staff analyzed data maintained by the central processing unit for the number of times HUSKY A coverage was either granted or denied for children initially receiving services under presumptive eligibility. As shown in Table III-2, *during calendar year 2001, 53 percent of children originally granted presumptive eligibility were then granted HUSKY A coverage, while 47 percent were not. For calendar year 2002, 59 percent of children granted PE were then granted HUSKY A coverage, while 41 percent were not.*

Table III-2. Presumptive Eligibility for Children Activity: January 2001—August 2003

	2. Final HUSKY A Granted by DSS Following PE	Final HUSKY A Denied by DSS Following PE*
January 2001 – December 2001	2,365 (53%)	2,129 (47%)
January 2002 – Dec. 2002**	3,073 (59%)	2,161 (41%)
January 2003 – August 2003***	Data not available	

* Reasons for denial include applicant non-cooperation with completing a full application, applicant already insured, or applicant over-income. Where appropriate, referrals were made for possible coverage under HUSKY B.
** The centralized presumptive eligibility unit within DSS was disbanded in late 2002.
*** Presumptive eligibility for children was eliminated in August 2003.
Source of Data: DSS Central PE Unit Monthly Tracking Reports

The main reason clients receiving services under presumptive eligibility were denied HUSKY A eligibility was because they did not complete the full application necessary for HUSKY A coverage. In fact, CPU data show that *of the 2,129 PE children denied HUSKY A coverage following PE during 2001, 1,660 (78 percent) were denied because they did not complete the full HUSKY application. In 2002, of the 2,161 PE children denied HUSKY A coverage, 1,534 applicants (71 percent) were denied because they did not complete the full HUSKY application.*

Application form. As mentioned above, prior to the elimination of presumptive eligibility for children, the department used a separate application for PE. The "fast form" was used for the PE period and the client then had to submit a regular HUSKY application when applying for regular Medicaid.

The committee believes *requiring clients to complete and submit two separate applications – even though the PE application was only one page – added an unnecessary step to the application process. It also created additional work for DSS, caused client confusion, and contributed to families not completing the regular Medicaid application process. A revised process using the same application for PE and regular Medicaid would greatly enhance the process, while also ensuring children were granted immediate access to care.*

There was also no limit on how frequently clients could use presumptive eligibility as a means to obtain medical coverage without applying for regular family Medicaid. Without such a limit, there was no incentive for clients to submit their full HUSKY application after service had been received and the immediate health care need was addressed.

The program review committee received testimony at its recent public hearings on this study that *presumptive eligibility for children should be re-established as a way to increase access to health care for children quicker than through the application process currently used for Medicaid. Healthcare access is increased through presumptive eligibility, yet as committee staff's analysis shows, that access is only temporary if a completed application for full Medicaid is not submitted.*

Re-establishment of presumptive eligibility for children would have a fiscal implication. The Office of Policy and Management and the legislature's Office of Fiscal Analysis estimate cost-savings of $2.8 million in FY 04 and $3 million in FY 05 as a result of eliminating presumptive eligibility for children. These estimated savings are gross savings, which include federal reimbursement. Estimated net savings to the state from eliminating presumptive eligibility is half the amounts shown after factoring out federal reimbursement. Based on those savings estimates, resumption of the PE option for children would likely cost around $1.5 million annually.

Based on the above analysis, the program review committee recommends:

The legislature should re-establish a program of presumptive eligibility for children by July 1, 2005. Funding should be restored to DSS to fully implement the program.

The presumptive eligibility process administered by DSS should be modified to better ensure clients/qualified entities fulfill application requirements for regular Medicaid at the same time presumptive eligibility is determined. At a minimum, a single application should be used to:

- **quickly determine presumptive eligibility by the qualified entity; and**

- **transmit the application and necessary information to DSS allowing the department to determine eligibility for HUSKY A benefits.**

Rationale. The committee believes restoring presumptive eligibility for children would increase access to immediate medical care for children. The percent of children applying for full HUSKY benefits would also increase with a more efficient and effective application process, as recommended. Further, if the on-line application process for HUSKY, as recommended in

Section 4, is implemented, it should provide for quicker application processing and eligibility determination.

Although the cost savings during FY 05 from eliminating presumptive eligibility are estimated at roughly $3 million, federal reimbursement is available for half the costs associated with PE. Thus, the estimated FY 05 state expenditure for resuming presumptive eligibility for children would be approximately $1.5 million.

State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP), established in 1997 under Title XXI of the Social Security Act, allows states to provide medical coverage to a broader group of children with higher family incomes than those covered under Title XIX Medicaid. Federal reimbursement for this program is 65 percent.

Connecticut implemented its SCHIP program in early 1998. The program is administered separately from the state's Medicaid program, but services to families are provided under a managed care structure similar to Medicaid. In Connecticut, the SCHIP program is referred to as "HUSKY B," while the state's Medicaid program is "HUSKY A." As of September 2004, a total of 14,647 children were enrolled for medical coverage in one of the three managed care organizations serving the HUSKY B program.

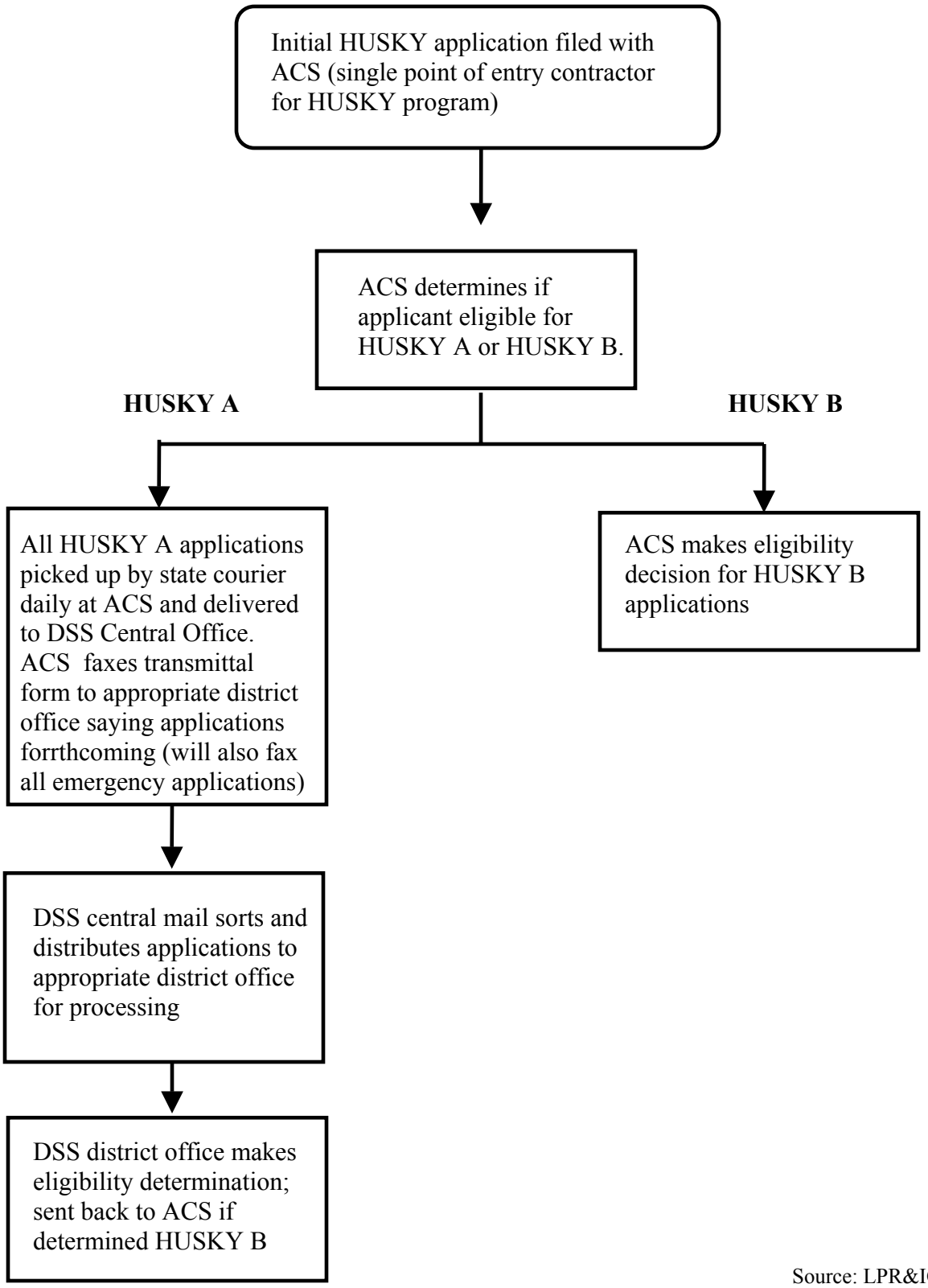
A private company, Affiliated Computer Services-State Healthcare (ACS), under contract with the state, carries out four main functions under Medicaid and SCHIP. The company: 1) is the state's Medicaid managed care enrollment broker for both HUSKY programs (since 1995); 2) serves as the state's single point of entry provider for family Medicaid (since 1998); 3) calculates monthly capitation fees due to managed care organizations for HUSKY A (since 2001); and 4) determines eligibility for HUSKY B applicants (since 1998). *The contract cost for the 18-month period of July 2003 through December 2004 is budgeted at $6.9 million*, with administrative costs totaling $817,000 (12 percent.)

Application Processing

As the single point of entry provider, ACS is the state's clearinghouse for the HUSKY program. In this capacity, ACS: processes all HUSKY applications it receives, either by mail or phone; screens applications to determine if applicants are eligible for HUSKY A or HUSKY B; refers all HUSKY A applications to DSS; and determines eligibility for HUSKY B applications. (HUSKY B is not under Title XIX Medicaid rules, which require that only a state agency can make the eligibility determination for Medicaid applications.)

Figure III-6 outlines the steps taken to process new HUSKY applications through the single point of entry system. The same application form is used to apply for either HUSKY A or HUSKY B. The HUSKY application process emphasizes a mail-in system, whereby applications are mailed to ACS. However, HUSKY applications are also filed directly with DSS offices. A more detailed application is also filed directly with district offices whenever someone is applying for an assistance program(s), such as food stamps or TANF, in addition to medical insurance.

Figure III-6. Single Point of Entry Application Process For New HUSKY Clients.



Source: LPR&IC Staff

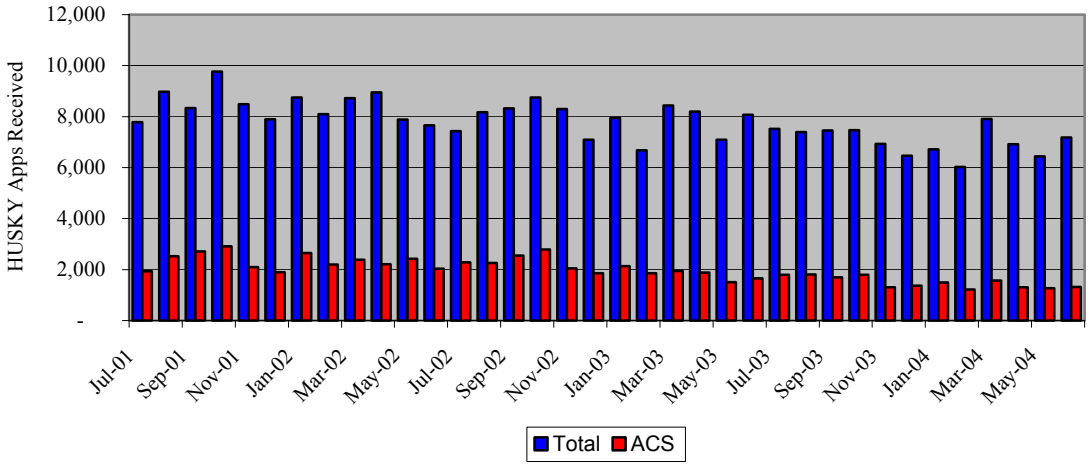
A contract with DSS outlines ACS' various responsibilities. For example, ACS is required by contract to collect specific client information as part of its eligibility screening process. This includes obtaining any missing information on the application or verifying items, such as questionable income. The contract also speaks to turnaround times, as discussed below.

The state courier service makes a daily mail stop during the week at ACS to collect applications and other mail. Applications determined by ACS to be HUSKY A are then delivered to the DSS central mail center for sorting and distribution to district offices.

ACS faxes a transmittal form to district offices informing them of any forthcoming applications. (Applications considered emergencies are faxed directly to the appropriate district office for processing.) Once HUSKY A applications are received at the district offices, DSS eligibility workers determine the applicant's eligibility.

Even though ACS is the state's single point of entry for receiving HUSKY applications, applications are also received directly by the department's various district offices. As a way to determine the proportion of Medicaid applications received by ACS, committee staff analyzed the number of new HUSKY applications received through ACS compared to the total family Medicaid applications received by DSS statewide for FYs 02-04. Figure III-7 illustrates the results.

Figure III-7. Number of Total New HUSKY Applications Received Through Single Point of Entry Provider: FYs 02-04



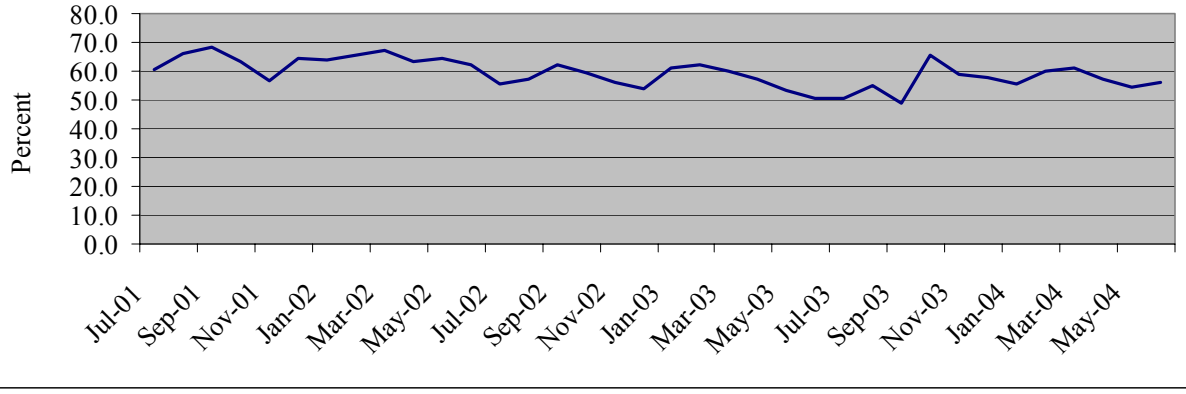
The numbers in Figure III-7 were derived from both EMS and ACS data on application activity showing total new family Medicaid applications received by district offices and ACS. The figure shows ACS received between 1,400 and 2,900 applications a month for the period analyzed, while the total applications received by DSS during that time ranged from 6,000 to 9,800. Although not shown in the figure, on average, ACS received 25 percent of all new family Medicaid applications submitted monthly for the time period analyzed. *This indicates that*

despite efforts to streamline the HUSKY application process using the single point of entry provider, DSS is still receiving the vast majority of applications for family Medicaid in its district offices.

The relatively low percentage of applications processed by ACS is partially due to the fact that applicants applying for programs (like TANF or food stamps) in addition to Medicaid, use a different application than those only applying for HUSKY. The more detailed applications have to be processed through DSS, and not ACS, but are counted in the monthly Medicaid application activity data for DSS district offices. In other words, the percentage of applications received through DSS would be lower if it only processed HUSKY applications, rather than applications that also included other programs. Regardless, the bulk of applications for family Medicaid are processed through DSS and not the state's single point of entry provider.

ACS application activity information was also analyzed to assess the percent of new applications processed each month by ACS and ultimately referred to DSS to determine HUSKY A eligibility. Figure III-8 shows *between FYs 02-04, a monthly average of 60 percent of the applications processed by ACS were referred to DSS as HUSKY A.* This trend has gradually decreased over the period analyzed.

Figure III-8. Percent of Applications Received by ACS Referred to DSS as HUSKY A: FYs 02-04



The high percentage of applications referred to DSS as HUSKY A is significant for several reasons. First, ACS is required by contract to pre-screen applicants (i.e., collect income, demographic, residency, and household information) to make an initial determination whether the applicant is eligible for HUSKY A or HUSKY B. Second, *the time it takes ACS to gather information from applicants who are ultimately referred to DSS, counts against the 45-day federal standard of promptness DSS has to determine a Medicaid applicant's eligibility*. Once a signed application is received by ACS, the standard of promptness period begins. If the information collected by ACS for cases referred to DSS is either questionable, missing, or takes too long to collect, a delay in meeting the standard of promptness could occur.

Application Timeliness

The overall time it takes ACS to process HUSKY applications is crucial to DSS' meeting the standard of promptness for Medicaid. ACS supplied committee staff with application processing time data for FY 04, as shown in Table III-3 The table highlights the time it took ACS to refer HUSKY A applications, from the date a signed application was received at ACS, to the date it was referred to DSS as HUSKY A. It should be noted, the ACS contract requires all signed applications have the "appropriate action" taken within 30 days of receipt, meaning applications, whether HUSKY A or HUSKY B, must be processed within that time period. The contract also requires all applications referred to DSS be done so "within two days of processing." (Contract provisions are discussed in more detailed below.)

Table III-3. Time at ACS for HUSKY A Applications Referred to DSS: FY 04

	1-10 Days	11-20 Days	21-30 Days	> 30 Days*
Total Applications (n=14,277)	8,552	3,455	1,028	1,242
Percent of Total	59.9	24.2	7.2	8.7

*ACS contract terms specify a 30-day limit to process all signed applications from the date received.
Note: For the period analyzed, ACS received an average of 1,190 applications per month and the average processing time was just under 12 days.
Source: LPR&IC Staff Analysis of ACS Data

Table III-3 shows for FY 04, *91 percent of applications determined HUSKY A were referred within the 30-day timeframe.* ACS notes the nine percent of applications processed beyond 30 days was generally due to waiting for missing information requested from an applicant. However, *for the 16 percent of applications referred to DSS after 21 days, a good portion of the time for meeting the standard of promptness has already lapsed.*

Realizing applications must be processed quicker, DSS and ACS are working on a revised process whereby ACS, will make all HUSKY A referrals to DSS within 10 days, even if there is missing information. Implementation of the new procedure is anticipated by the start of 2005.

Table III-3 also shows the average time it took ACS to refer HUSKY A applications to DSS was just under 12 days for FY 04. This is relevant because, although the contract requires "appropriate action" be taken on applications within 30 days of receipt, it also requires all referrals to DSS be made within "two days of processing." What is not clear in the contract, however, is the meaning of the term "processing." Although this discrepancy needs to be resolved within the contract language, the committee believes applications can be processed by ACS quicker given much of the relevant information contained in a HUSKY application is now

self-declared by the applicant. This means that unless the required information is either missing or questionable, an application should be processed without the client having to submit additional material to "verify" the application information, thus shortening the overall processing time.

Contract

The state originally entered into a contract for enrollment broker services in 1995. The single point of entry function and the passive billing (i.e., determining capitation rates) responsibilities were added as amendments to the original enrollment broker contract in 1998 and 2001, respectively. *Although the contract has been amended several times, it has never formally been rebid since its inception in 1995.*

Original language in the 1998 amendment to expand the contractor's scope of services speaks to "proposed" performance standards, but has never been revised to reflect formal performance standards, or updated to account for programmatic changes. For example, as mentioned above, the single point of entry provider responsibilities within the contract require ACS to forward all signed applications to DSS within two days of "processing," even though the term processing is ambiguous and not clearly defined in the contract language. Whether "processing" means from the time the application is received or from the time ACS collects the required information to determine initial eligibility, is not addressed in the contract.

The committee believes *the larger issue, however, is for DSS and ACS to find the proper balance between ACS processing HUSKY A referrals quickly, but sending DSS applications that have proper and complete information so that eligibility workers can make a determination, which is the whole intent of the single point of entry system.* The department and ACS are currently discussing whether the process should be changed to reflect more reasonable processing standards, balanced with the level of information ACS would collect and forward to DSS as part of the referrals. The committee believes this process change needs to occur and be formally outlined in the contract, as recommended below.

There is also *no provision in the current contract for sanctions of any kind, other than termination, if contract terms and performance standards are not met.* Additional administrative measures to correct procedural or performance deficiencies, such as requiring a "plan of correction," are not addressed in the contract. Outlining a progressive enforcement procedure in the contract would provide DSS and the contractor with a clearer understanding of the ramifications if contract terms and performance standards are not upheld.

Based on the above analysis, the program review committee recommends:

DSS should develop a request for proposals for a new contract for the department's HUSKY single point of entry and enrollment broker services currently provided by an outside vendor. DSS should also decide whether or not to separate the single point of entry and enrollment broker functions, which are combined in the present contract.

The single point of entry provider contract language for the HUSKY program should include: formalized performance standards; specified time limits required to process HUSKY applications; and an established level of review required by the vendor to assess eligibility as either HUSKY A or HUSKY B prior to referring an application to DSS, measured by the percent of complete application submitted to DSS for eligibility determination.

DSS should place a maximum of five years on the life of any new HUSKY single point of entry provider and/or enrollment broker contract(s). Any new contract(s) should include a specified process for identifying and correcting non-compliance with contract terms, including corrective action plans and punitive sanctions, when applicable.

DSS should regularly monitor the performance of the state's single point of entry provider for the HUSKY program – with an emphasis on application processing – to ensure contract terms and performance standards are consistently achieved.

The state's enrollment broker should be responsible for implementing the revised change of address system, as recommended earlier in this report.

Rationale. The committee believes the single point of entry provider/enrollment broker contract needs to be re-bid with more formalized performance standards and enforcement processes and as a way to ensure the most efficient and effective processes are in place. The current contract language is outdated and vague in several areas, as highlighted above. A new contract, with an emphasis on application processing, should eliminate ambiguities in the current contract language. Also, limiting the life of the contract and outlining a specified process for identifying and correcting areas of poor performance, including sanctions, should help ensure adequate contractor performance.

Further, with six years' experience with the single point of entry system, DSS should better anticipate what the volume of HUSKY application activity the contractor will assume and gauge the contract amount accordingly. Also, the recommendation to limit the number of times Medicaid clients can change MCOs in a given year, as recommended below, should reduce the enrollment broker administrative activity, thus reducing anticipated costs in that area.

Provider Access Under Managed Care

The committee wished to assess whether or not Medicaid clients have adequate access to service providers. Committee staff analyzed three sources used by DSS to gauge that access for HUSKY A clients, including: 1) MCO network adequacy measures for key types of providers (e.g., physicians and specialists in internal medicine, pediatrics, obstetrics and gynecology, dentists, and behavioral health providers); 2) the current annual quality review of managed care organizations done by the DSS external review contractor; and 3) reasons MCO enrollees change plans as tracked by the state's Medicaid managed care enrollment broker, ACS.

Network adequacy tracking. DSS determines current MCO network enrollment capacity levels based on a ratio of providers to Medicaid clients calculated using the number of fee-for-service (FFS) providers accepting Medicaid clients in 1994, the year preceding the state's switch to Medicaid managed care, and the number of Medicaid clients at that time. The department then measures overall member enrollment against the capacity levels to identify those MCOs with high network capacity levels by type of provider. The ratio of Medicaid clients to fee-for-service providers has not changed since it was originally calculated in 1994.

MCO contracts specify that if enrollment within an MCO reaches or exceeds 90 percent capacity for a certain type of provider (e.g. dentists), the plan has 30 days to add providers to maintain acceptable network capacity levels. DSS monitors the MCO's progress on a monthly basis to ensure efforts are made to add providers.

If a managed care organization reaches 100 percent capacity for a particular provider type within a county, DSS issues a warning letter to the MCO identifying the problem. The department has the option of suspending the MCO's enrollment for that particular county until the problem is corrected. The MCO contracts provide for corrective action plans when enrollment is suspended, and allow sanctions for each month enrollment suspension continues beyond the corrective action date.

Committee staff examined monthly reports for June through November 2004 to assess whether any MCOs experienced access issues with particular types of providers. The reports also show whether any warning letters have been issued or enrollment suspensions are in effect.

Overall, the reports showed: 1) no MCO ever reached 100 percent capacity for any type of provider; 2) no warning letters were sent to any MCO; and 3) no enrollment suspensions were issued due to network inadequacy. Specific concerns highlighted in the reports, however, showed several instances where a managed care organization was over the 90 percent threshold for a particular county, but for dentists only. DSS noted it is monitoring this issue to ensure the MCO network does not reach full capacity and warrant an enrollment suspension, thereby limiting access. Long-term, DSS is planning a dental carve-out to begin in February 2005 to address dental access.

Annual quality review. Federal regulations require state Medicaid agencies to conduct an annual quality review of each managed care organization to determine if operations and practices are adequate to serve Medicaid enrollees. In Connecticut, DSS contracts with an external company to conduct the reviews, and the most recent completed annual review was done in late 2002 – the department was granted a waiver by CMS for its 2003 review. Also, while the 2004 review has been conducted, the contractor's report is still in draft form, and not available for examination.

One area examined during the 2002 quality review is "access and services availability," in which several components are measured against specified standards developed by DSS. The areas reviewed for this particular category included: 1) availability of both emergent and urgent care; 2) the MCO's responsiveness in scheduling timely appointments; 3) the MCO's monitoring activities to handle member inquiries and access issues; 4) the MCO's preventative health assessments; 5) provisions for early and periodic screening, diagnosis, and treatment services

(EPSDT); and 6) provisions for prenatal care services. The quality review report gave Connecticut's Medicaid MCOs an acceptable (or above) rating on each of the criteria evaluated for "access and service" availability.

Client MCO changes. ACS, as the state's Medicaid managed care enrollment broker, tracks reasons that enrollees change plans. Committee staff examined the monthly tracking data for FY 04. Although client reasons for changing MCOs are varied, there were several that would possibly indicate problems with accessing care, including:

- cannot find primary care physician (PCP)/dentist taking new patients;
- client's PCP left plan;
- continuous inappropriate denial of care;
- denial of services;
- language barriers with providers;
- long waiting times at doctor's office;
- longer than one day wait for urgent care, three day wait for non-urgent care, or one month for visit;
- plan's providers too far or problems with plan's transportation; and
- trouble getting durable goods or prescriptions.

In total, these issues accounted for only 5.2 percent of the reasons clients changed managed care plans during FY 04.

Overall, based on the above methods to gauge Medicaid clients' access to care, the committee concludes access is not problematic. However, staff finds the way DSS calculates MCO enrollment capacity levels, based on 1994 fee-for-service and Medicaid client figures, is outdated and sets higher enrollment capacity levels than if the levels were determined using a more current, and broader, methodology.

Unlimited plan changes. Adequate access to care and continuity within a managed care plan are important components of health care for Medicaid clients. Currently, however, clients are allowed to switch MCOs any number of times in a given year. According to data from ACS, a total of 35,294 HUSKY A recipients changed managed care plans during FY 04, an average of 3,000 recipients changing per month. This represents 12 percent of the average monthly MCO enrollment for HUSKY A for that year.

Allowing clients an unlimited number of changes to their managed care plans also creates administrative problems, and presents issues regarding continuity and coordination of care. If clients know they can frequently change plans, they may be more apt to make such changes for reasons other than what would normally be considered "good cause." Also, given clients' ability to change managed care organizations any number of times, providers most likely experience record keeping problems when clients change plans and MCOs undoubtedly incur greater administrative costs associated with enrolling new members. Therefore, the committee recommends:

DSS should place a limit on the number of times Medicaid managed care clients may change managed care plans to once every six months. More frequent changes may be made if the client has a "good cause" reason to make a plan change, as determined by DSS.

The committee believes implementing a limit on the number of times Medicaid clients can change their managed care plans is a more efficient system than the process of unlimited changes currently in place, both administratively and from a continuity of care perspective. Allowing clients to switch managed care plans a maximum of twice per year, unless good cause is determined, should help decrease administrative processing on part of DSS, the state's enrollment broker, managed care organizations, and providers. The recommendation is also within federal guidelines, which require enrollment periods of no longer than 12 months without allowing clients to change plans. Further, clients should experience greater continuity of care by staying with a health plan for a longer minimum time period than is currently required. Implementing this recommendation may also result in cost savings for DSS in its contract with the state's Medicaid managed care enrollment broker if fewer clients switch managed care plans during the year.

Unlike Medicaid clients, HUSKY B clients may change managed care plans one time per year. If, however, a HUSKY B client has a "good cause" reason for wanting to change plans, such as the client's primary care provider is no longer in the current plan, a change may be requested. ACS examines the request based on guidelines provided by DSS and decides whether to grant or deny. Under the proposed recommendation, Medicaid clients would also be allowed to change their managed care plan more frequently than twice a year for "good cause reasons" as determined by DSS.

Medicaid Fee-for-Service Access

There are no similar provisions for adequacy for Medicaid clients who are in fee-for-service (FFS), and not in managed care. With FFS, federal regulations require that Medicaid rates established in the state be sufficient to enlist enough providers to ensure Medicaid clients have similar access as among the general population.

Without similar measures in place as for MCOs, adequacy of access for the FFS population was more difficult for program review to determine. A listing of all current Medicaid providers is listed on Connecticut's medical program website (not DSS'). That listing indicates a total number of about 5,700 providers of all types and specialties statewide. However, this listing includes nursing homes, clinics and substance abuse facilities. It also includes providers listed multiple times, if they have different locations or have more than specialty. Thus, it does not seem to provide a true picture of provider adequacy.

Further, as the website cautions, these providers may not be taking *any* new patients, may not be open for additional Medicaid clients, or may limit those appointments to certain hours or days of the week. Again, the listing itself is not a very reliable adequacy measure.

However, according to the list, the number of general practice physicians for adults statewide is only 234, a seemingly low number considering there are about 60,000 adults in FFS Medicaid. Also, in visits to DSS offices, department staff indicated that getting an appointment

with some provider specialists, like orthopedics or psychiatry, can be very difficult, and clients may have to wait months.

Measuring adequacy of client access to providers was beyond the scope of the study, and there are no clear standards in place – like provider to patient ratios – by which to evaluate adequacy. Thus, the committee makes no finding about the adequacy of number of providers in Medicaid fee-for-service, but believes DSS should better communicate the website information on providers participating in Medicaid to make it more accessible.

Long-term Care

The staff briefing report showed long-term care cases declined about 8 percent – from 22,160 in FY 00, to 20,408 in FY 04. At the same time, new applications for long-term care also decreased – from an average of 1,042 applications per month in FY 01, to 938 in FY 04. However, the percentage of overdue applications (i.e., beyond the 45-day SOP) for long-term care continues to be problematic. Fifty-five percent of pending applications were overdue in FY 01; by FY 04, almost 60 percent were overdue.

As indicated in the briefing report, processing initial applications for Medicaid long-term care is labor-intensive because DSS must examine financial records and conduct complicated tests and calculations before granting eligibility. For example, if a spouse is still living in the community, DSS staff must determine what assets can be protected for that spouse, what income the community spouse can keep as a monthly needs allowance, and whether assets the applicant transferred during the look-back period (36 months) were exempt by law, and, if not, what penalty should be assessed.

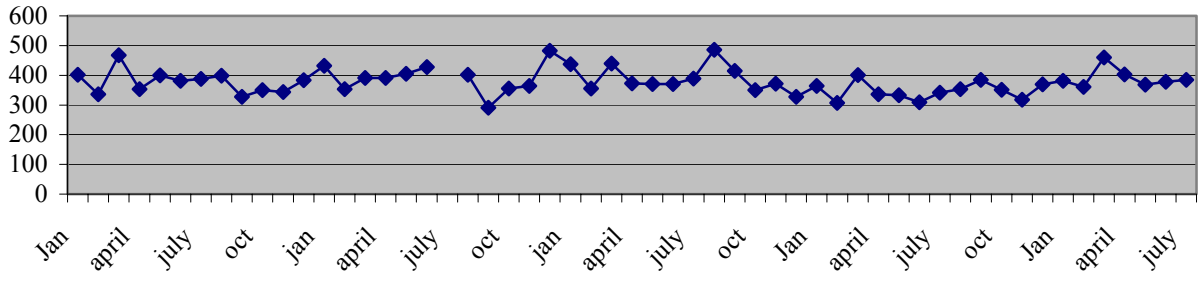
Adding to processing delays is the difficulty in obtaining all the financial records necessary to determine the application. If the client does not have these records, they must be obtained from banks, insurance companies, or other financial institutions, and there are often delays in DSS obtaining the records. Frequently, the applicant may not be physically or mentally able to obtain or organize the necessary documents, and family members and/or attorneys often become involved.

Delays in determining eligibility can have serious financial consequences for clients and/or nursing homes, if a client is already residing there. For example, if, after an extended application review period, a client living in a nursing facility is found ineligible, the client faces a significant bill for care that he or she cannot pay. According to the association representing nursing homes in Connecticut, the nursing facility must absorb the loss, possibly creating a substantial cash flow problem.

Home- and Community-Based Waiver (HCBW) program. In 1995, Connecticut was granted a Medicaid waiver, which allows services to be provided to a client in the community if the person would otherwise be placed in a nursing home. The five-year waiver was renewed in 2000, and there are currently more than 10,000 recipients in the waiver program.

Applications for the waiver program undergo a similar, comprehensive review as long-term care applicants. DSS staff examined financial and asset records for the three years prior to the application. Initial applications for this program currently total about 400 a month, about half the number of new long-term care applications filed, as shown in Figure III-9.

Figure III-9. Home and Community-Based Waiver Program
Number of New Applications Per-Month: January 00-June 04



As pointed out in the briefing, because nursing home care is expensive (about $92,000 a year on average) and long-term, there is a public interest in ensuring that only persons who are truly needy are granted eligibility. The examinations required to prove that need are especially pertinent in an affluent state like Connecticut, but policies indicating which financial transactions require additional follow-up and verification may be overly stringent.

However, given: the number of applications received per month for both long-term care and the HCBW program; the need for a comprehensive review of financial records; the consistently high percentage of overdue pending applications at the end of the month; and the increased involvement of attorneys in this area, the committee finds the 45-day standard of promptness to determine eligibility is unrealistic.

Therefore, the committee recommends that DSS, working with the governor's office and the legislature's Human Services Committee, submit a waiver request to the Centers for Medicare and Medicaid Services (CMS) extending the standard of promptness for long-term care applications to 90 days. Longer-term, DSS, the governor's office and the legislature should also begin working to have the regulations concerning standard of promptness, as it applies to long-term care, changed.

Allowing a longer period of time to process applications will mean that fewer applications are over the SOP. However, it will not mean that eligibility is determined more quickly. To help expedite the process, the committee recommends the following:

When DSS first receives a long-term care application, the eligibility worker should immediately contact the client, or whoever is making the application on the client's behalf, to inform that person that the DSS eligibility worker is reviewing the case. The eligibility worker should explain that the process is complex, and heavily reliant on the review of financial and asset documents.

The policy setting the guidelines in investigating applicant checking accounts should be changed to require workers to only question amounts that might affect eligibility.

Rationale. Implementing these steps should help expedite the process by improving early communication about who the eligibility worker is and how the eligibility process will be handled. The policy on transfer of assets concerning checking accounts and the amounts that need investigation -- $500 if not part of a normal pattern, and "questionable" $1,000 amounts – has not been updated since 1993. The committee believes specific amounts should not be in policy, but allow worker discretion to investigate or require verification for amounts that might affect eligibility. This is similar to the policy established for savings accounts.

Redeterminations for Long-Term Care

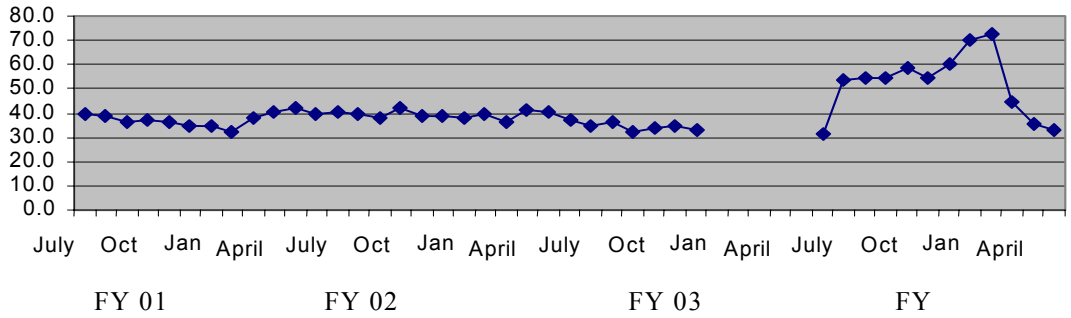
As with other Medicaid cases, long-term care clients must have their eligibility renewed each year. DSS offices typically process 1,200 to 1,300 long-term care renewals each month.

Discussions with DSS staff indicate that long-term care clients' circumstances rarely change, which should make redeterminations relatively simple. In fact, *more than 90 percent are awarded renewed benefits, and typically less than one percent are automatically discontinued because of failing to complete the redetermination process.*

Despite this, a problem exists with overdue renewals in this Medicaid category as well. Figure III-10 shows that, generally, between 30 and 40 percent of long-term care renewals had been overdue from FY 01 through mid-FY 03. However, after the staffing reductions and the suspension and subsequent resumption of renewal processing in May 2003, the percentage of overdue long-term care renewals increased to well over 50 percent for a few months, before declining to its more typical 30-40 percent level in the last couple of months of FY 04.

Further adding to the overdue problem in late FY 03, was a change in what had been a DSS informal practice. Without official approval, DSS had been informally operating a two-year renewal for long-term care clients by broadening the scope of an existing waiver giving DSS the ability to redetermine elderly food-stamp clients only once every two years. However, the state auditors cited DSS for this when the single-state audit was conducted in 2003. The department then resumed one-year redeterminations for long-term care.

Figure III-10.Percent of Long-Term Care Renewals Overdue
FY 01-FY 04



The committee concludes that DSS continues to issue benefits to these clients beyond their renewal periods. Workers understand that the vast majority of clients will be renewed when the eligibility worker has time to review the documentation, with little risk of continuing eligibility for someone who will be denied.

The committee believes that since the nursing home population is such a stable one -- whose eligibility for Medicaid is "long term" and whose eligibility circumstances do not generally change, the renewal period ought to be extended. **Therefore, the committee recommends that DSS submit a waiver request to CMS to allow a two-year redetermination period for long-term care clients.**

The department could use the statistics on its redetermination activity to support such a request. With less than one percent denied because of failure to comply and the vast majority being awarded at renewal time, the committee concludes that yearly renewals are not a good use of staff or EMS resources. If those resources could be redirected to determining eligibility for initial long-term care applications, it would help reduce delays, as well as the financial impacts on clients and nursing facilities if found ineligible after a prolonged review period. DSS should formally request a waiver to ensure they meet all rules and regulations and therefore cannot be cited in future audits.

Section 4: Operations and Support Systems

Eligibility Management System

Eligibility workers rely heavily on DSS's computerized eligibility management system (EMS) to determine a client's initial and continued eligibility for the state's major public assistance programs, including Medicaid. Program review staff believes an overhaul of the current eligibility management system would greatly assist in reducing application processing times and increasing access to needed benefits for eligible persons. However, staff also recognizes that such an overhaul will take considerable time and resources to develop.

The current EMS is a mainframe system initially developed in the 1980s, and consists of 68 databases, more than 1,500 programs, 336 screens and over 4 million lines of code. As pointed out in the staff briefing, the system determines eligibility, issues notices, and calculates and sends benefits to about 227,000 households. It maintains the eligibility information for almost 400,000 Medicaid clients each month.

It receives information entered from over 1,500 terminals across the state, and EMS exchanges and matches data with other state and federal agencies, as well as with towns, banks, insurance companies, and other entities to monitor and verify information concerning clients and their eligibility.

The EMS system does not provide eligibility workers with the more "user-friendly" interface identified with personal computers, and the system is "rigid", requiring programming or reprogramming each time a change in policy or eligibility criteria is made. Because of the system's technological deficiencies, eligibility workers are often required to "work-around" or circumvent the system to implement a policy or procedural change in the Medicaid program.

Despite its flaws, workers and DSS management defend the system, stating Connecticut's Medicaid error rate has never been above the three percent national standard, that it is less prone

to security breaches, and that it adequately performs the functions to determine eligibility and issue benefits to almost 400,000 people.

The committee believes that DSS has been able make additions, adaptations, and modifications to the EMS system over the years so that the department could adequately deliver its programs and services to clients. Certainly in comparison to systems in other states, Connecticut's is reliable. However, the capacity of EMS may be reaching its limits, and the committee believes DSS should begin planning now for a replacement system so that it can be done in an orderly, planned way, rather than reacting to a crisis if the EMS system were to fail.

Committee staff called a number of states about their computerized EMS systems and learned that those states that had introduced a new computerized eligibility system had planned for the system for at least five years. New eligibility management systems are also expensive – Maine spent $22 million for its Automated Client Eligibility System (ACES), and Colorado is reported to have spent more than $100 million on its new computerized eligibility system. (See Appendix B for states surveyed and a summary of responses.)

The committee believes there is recognition within DSS that EMS will need to be significantly upgraded or replaced. While DSS has not submitted EMS replacement to the Office and Policy and Management as a budget option, OPM indicated to committee staff that DSS had sent OPM a letter sometime in the last three years alerting OPM that the system would need to be addressed and that it would require significant financial support. According to OPM, the estimated cost for the new EMS system was in the "tens-of-millions of dollars", and OPM stated there was no money for such an option.

The committee believes the EMS system is absolutely essential to the eligibility determination process. It seems risky to keep relying on an old, overburdened system without planning for a significant upgrade or replacement. Since the planning process in other states has been lengthy, it would seem that Connecticut could also expect a long time frame to design and implement a new system. Recognizing the lengthy process, the committee recommends:

> **DSS should begin taking the initial planning steps for an EMS replacement now. First, the department should attempt to secure funding through a variety of sources: federal funding, grants, or matching private grants with state funding. Second, by July 1, 2005, DSS should designate a planning team, with representatives of "end users" (i.e., eligibility workers), DSS and DoIT management information personnel, as well as agency management and budget personnel to begin a comprehensive needs assessment as a foundation for system planning. These steps should occur before a request for proposal is developed, and consultants secured.**

Rationale. The committee recognizes a system replacement for EMS will take time, but believes if approached in an organized fashion it will go more smoothly and be less of a distraction to clients and staff than if the situation becomes urgent. Staff also recognizes that with the staffing cuts and office closures, the department is hard-pressed to conduct daily operations, without having to plan for and implement a system overhaul. However, if done as a long-term project, it should not impact as heavily on everyday staff functions.

There must also be a commitment of state monies for such a project. DSS must begin pressing its need for a new EMS system to OPM and the Legislature, and those involved in the budget process must find financial support. As indicated in the briefing report, Connecticut spends a lower percentage on Medicaid administration than any other New England state. The committee believes increasing the administrative costs to help pay for such a crucial part of the Medicaid system is fiscally responsible.

Further, if DSS could identify other sources of funding, and not seek only state monies, it would demonstrate the need for, and commitment to, the project. Given the system will take years to develop and implement, funding could be budgeted each year as the project is developed, or the possibility of bonding the project as a capital improvement could be explored.

Updating notices. A related EMS initiative, in which DSS has already made progress, is updating many of the notices created by EMS and sent to clients so the notices are shorter and easier to understand. Advocacy groups and others believed the notices were too long and too confusing. The initiative, funded by the Robert Woods Johnson Foundation, was implemented in two phases. The first phase, begun in February 2001, was to identify issues with the notices with a major focus on family Medicaid. The first phase used Arthur Andersen Consulting, who conducted focus groups in the regions involving staff and consumer groups, including legal aid attorneys, to identify issues with the notices. The second phase was to develop new notices and program DSS software to generate the replacement notices. DSS used Maximus consultants for the second phase, but indicates that considerable DSS staff time also was needed to implement the changes. Most of the 16 notices that were modified are still being piloted.

The committee believes this is clear demonstration that DSS actively works to improve the application and eligibility determination process. In this case, DSS partnered with advocacy groups and other consumers, secured outside funding for the project, appointed committed staff to the initiative, and is in the final stages of piloting and implementation.

The committee recommends that DSS continue its process of upgrading notices to include programs in addition to family Medicaid. The committee also recommends that DSS begin a review of the worker alerts generated by EMS, with the objective of keeping only those that are helpful to workers.

The committee recommends that both initiatives be implemented as long-term, in-house projects, within allowable resources. Project teams developed to examine EMS alerts should include eligibility workers who can help decide which "alerts" are of no value in managing workload. Further, a prioritization system -- those with greatest impact on client eligibility given the highest priority-- could be established for those alerts maintained on the system.

De-linking in EMS. One of the provisions of the federal Personal Responsibility and Work Opportunity Reconciliation Act (welfare reform) of 1996 requires states to sever the link between eligibility for cash assistance and Medicaid. The EMS system in Connecticut has not yet accomplished this. As discussed in the "change-of-address" issue, this link can have negative

consequences to the client, discontinuing his or her Medicaid benefits because of returned undeliverable notices for another program.

Further, severing the link has become more important since October 1, 2004, when more stringent requirements for those time-limited TFA clients to keep appointments for employment assessments went into effect. DSS indicates the delinking of family cash asssistance and Medicaid should be complete in early 2005. Given the impact the continued tie in the EMS system can have on a client's Medicaid eligibility, the department clearly needs to meet that deadline.

The program review committee recommends that DSS complete the de-linking of the TFA and Medicaid eligibility in the EMS system by March 1, 2005. Other EMS links between other client assistance eligibility (e.g., food stamps) and Medicaid should be completed by October 1, 2005.

ONLINE APPLICATION

Currently, Connecticut does not offer system capability for clients or others to file an application online. Other states have begun offering electronic application processing as a way to improve access to the Medicaid program. At least eight states have some form of statewide online enrollment for family Medicaid and SCHIP, and another eight states have more limited pilot programs underway.

Committee staff reviewed the literature regarding online Medicaid applications and contacted many of the states currently providing online capabilities to draw from their experience, and assess what, if any, elements Connecticut might wish to adopt with such a system. (See Appendix B)

According to one report, all states that have these capabilities refer to their systems as " 'online enrollment' or 'online application'; the individual functionality differs greatly across efforts."[3] However, as the report's assessment indicates, state systems fall into one of the following four basic types:

- **Online enrollment with an automated "back end"**: This system uses an automated process to capture, save and transmit the applicant's data to the Medicaid programs' eligibility database. This approach offers the greatest administrative efficiency because the data are automatically sent to a computerized eligibility system; however, security measures must be implemented to protect the transmission, storage, and retrieval of the applicant's data. Georgia's SCHIP and Medicaid for children programs (PeachCare) use this type of system -- where most applicants can self-declare income and electronic signatures are accepted. Michigan, Pennsylvania, and

[3] California HealthCare Foundation "Public Access to Online Enrollment for Medicaid and SCHIP", May 2003

most of California also use this type of system, even though hard copy signature pages and income documentations are often needed separately to complete the application.

- **Online applications submitted electronically to the program:** This system captures, saves, and transmits data from the user and submits it to the program. Eligibility staff then print the applications and process the information as if received in the mail. This system does not have the same security issues, but is duplicative, requiring data to be entered twice. Users are notified electronically that their application has been received, and sometimes of the tentative eligibility. Utah, Washington, and some California counties, operate this type of system.

- **Online application assistance tools:** With this system, users enter their eligibility data into a web-based application assistance program that provides helpful information and flags any errors in the form. At the end of the process, users are notified of their apparent eligibility for various types of programs, and advised to print the application and submit it by mail. Texas uses this type of screening system, and is in the final stages of developing an RFP to incorporate full online application capability.

- **Online applications available to download:** With this system, applications are available to print. The applicant can then complete and mail in. Many states have this capability, and it saves the cost of mailing an application, or the client coming in the office to complete it, but it does not really provide online access.

Other variations. Some states allow anyone with Internet access to file an application, while others such as California limit access to agencies that are "certified application assistants." Most states have the applications available in English or Spanish. Some states limit online access to Medicaid, or just family Medicaid, while others, like Pennsylvania and Washington, allow access to other major assistance programs like food stamps, long-term care, and school lunch programs.

The costs of planning, developing and implementing these systems also vary among states. Georgia was able to develop its system in four months at a cost of only $40,000. Washington indicates the state children's Medicaid portion of online access cost about $50,000, while in Texas, total costs were about $600,000.

California's Health-e-App took about two years to develop. The tool was piloted in 2001 in one county and was approved for statewide use in 2002. California's online system cost about $1 million. Initially, staff in California's Medicaid agency believed the state could claim an enhanced federal match (90 percent for development, and 75 percent for operational costs) but later learned the project was eligible only for the standard 50 percent reimbursement. California

did manage to leverage its state funding with private monies from the California Health Foundation.

Development of Pennsylvania's system (COMPASS) was begun in October 2001 and the first applications (Medicaid for pregnant women and children and SCHIP) were transmitted in October 2002. The initial cost of that program was about $500,000 for family Medicaid and SCHIP.

Participation: While online application capability clearly increases ways to apply for Medicaid programs, it is still a minor contributor to the overall application volume received in the states that employ such systems. For example, Georgia appears to have the highest participation – over 60,000 applications were received over a two-year period. Similarly, Utah had a high participation rate with its online application system. Utah allows applications only during open enrollment periods. The first two-week period where online application capability was available was in June 2002, and during that period 1,122 applications (18 percent of all) were received. In the next open enrollment period in November 2002, the number had increased to 4,191, or 45 percent of all applications.

Participation was significantly less in Washington and Pennsylvania, where applications transmitted online accounted for only five percent of all the applications.

The committee finds that other states' experiences with online access vary. While participation rates in filing online are not uniformly high, and costs and planning and development times vary significantly, the committee believes the increased client access to Medicaid is worth the effort. The committee believes Connecticut should develop online access capabilities and therefore recommends:

By March 1, 2005, DSS should begin the planning and development for online access for HUSKY applications only. The system should consist of an automated transfer of the application data to the EMS system. The online application should provide electronic signature capabilities, and the transmittal should be blocked if essential information and a signature are missing.

As part of that initial phase, DSS should estimate the costs for such a system and explore matching any state funding with private grant monies, and also determine the amount of federal reimbursement available.

The online application should be transmitted through Internet access. Security measures should be developed as part of the planning and development phase.

By March 1, 2006, the system should be ready to pilot. The department should work with its community partners – the CAP agencies, qualified entities, hospitals, Voices for Children, and other advocacy groups – to promote the use of such a system. By July 1, 2006, the system should be available statewide.

Rationale. The system should increase access by giving clients, qualified entities and other organizations another access tool. It should also allow community access agencies to submit an application immediately, on behalf of the client, and not rely on the client to "do it later". Making successful transmittal subject to full completion of the application should significantly reduce the submission of incomplete applications, and subsequent denials because of lack of complete information. In addition, this will reduce the high percent of overdue applications related to incomplete filings.

Even if participation starts out slow, it is likely to increase rapidly, as in the state of Utah. Further, the committee believes online access is a favorable alternative to in-person office traffic, or to mailed or faxed applications, which are more apt to be misplaced or lost.

The committee believes the online application should be initially limited to HUSKY (family Medicaid) because the application is short, simple, and requires only self-declaration of income and no supporting documentation such as asset information.

Some monies have already been allocated for this project during the 2004 legislative session. In the budget adjustments for FY 05, the legislature allowed DSS to keep up to $200,000, which would have otherwise lapsed in June 2004, for the procurement of MIS systems, specifically the development of statewide online Medicaid and HUSKY enrollment. DSS could solicit matching private funding, perhaps from the Robert Woods Johnson Foundation, which promotes efforts to ensure better health care access for low-income children and families.

The committee believes that the timeframe recommended is a realistic one, especially given the number of states that have already implemented such systems. Connecticut would not be pioneering these efforts, but could borrow from other states' experience in development, marketing and implementation. DSS indicates it is already surveying other states' capabilities as a first step in the planning process.

SUPPORT OPERATIONS

DSS staff also rely on other systems and operational support services to conduct the business of determining eligibility and assisting the client. The briefing report discussed variations and deficiencies among offices in phone systems, e-mail capability, office space, mail service, drop box availability, and security as examples of operational support issues.

Security. As noted in the briefing, during business hours, some offices have only one security officer on duty, while others have more than one private security officer and a local police officer on duty as well. In fact, one local police officer was on duty when an office committee staff visited was closed. Committee staff asked local office managers about this variation when staff conducted office visits in the summer and fall, and was told those decisions were made at the central office, not in the district.

Staff asked the Director of Operations at the DSS central office about the arrangement for security and the need for local police at some offices. He could not recall when the local police arrangements had begun, or the reasons, but thought it might have been as a result of risk assessments conducted by the state Department of Public Works (DPW). However, committee

staff reviewed all four of the risk assessments DPW conducted of currently operating DSS offices,[4] and found that in three of the four office assessments, the office already had local police on duty. The other office did not have a local police arrangement, nor was one recommended in the assessment.

Committee staff asked for the written contracts or personal service agreements DSS has with local police, for offices where that is part of the security, but was not able to obtain them. Thus, committee staff was not able to determine what functions local police are required to perform, nor what DSS is expending for the coverage. Staff review of the DPW assessments also indicated that incident reporting to DSS was a private security function, and the Hartford office assessment stated that there were no published "posted orders" (i.e., duties to perform) for police officers on duty.

At a time when DSS has cut its core services (eligibility workers) and closed offices, the committee questions the continuation of such agreements with local police departments for officer coverage at some offices.

Thus, the committee recommends that as contractual arrangements for police coverage expire, DSS substantiate the need for their continuation to the Office of Policy and Management and the Appropriations sub-committee responsible for DSS financial oversight.

Rationale. The committee believes DSS should be called to justify such expenditures at a time when core services and staff are reduced. Further, to allow a contract for police services to be provided at a closed office is certainly not a good use of scarce resources.

The committee also questions the need for this added police coverage at DSS offices when other state agencies serving a high volume of needy clients are adequately served with private security services.

If DSS retains these contracts, it should require established standards of performance and not include hours of coverage when offices are not open.

Phone systems. Variation also exists with the phone systems in district offices, including capacity for the number of messages that can be left on an individual's voice-mail, the messages clients hear when they call an office, and ability to assess call volume in any given office.

The DSS Director of Operations indicates that there are two phone systems in place at the DSS offices – one in the three largest offices, and a second system in place for all the other offices. The systems were installed eight or nine years ago, but the hardware is still at "industry standard", according to the operations director.

However, district office staff indicates the phones are problematic. Also, when committee staff asked for call volume through central office operations, it was difficult to get, and for some offices, not available. *According to central office operations, the systems need to be*

[4] The requirement for DPW to conduct such assessment became effective in 1999 (P.A. 99-220).Thus, all of these assessments occurred after that.

programmed to handle the necessary changes, the hard drives the systems depend on need to be defragmented, and district office staff need to be better trained in the use of the systems.

Copy and mail. Central Office Operations is also responsible for all copying for the regions and for the bulk of DSS mailing, including all the EMS-generated mailings, and central office mail. DSS is also included in the state courier route that picks up and delivers mail from different state agencies, ACS (DSS' enrollment broker), and its regional offices. *DSS office staff did not indicate any problems with the central mailing and copying system, although there was confusion in some offices about how they were getting applications and mailings from ACS.*

However, at least one office has a problem with the local postal service in that the DSS office is not on the pick-up route. *Thus, one staff member from the DSS office is designated each day to deliver the mail to the local post office*.

Electronic communication. In the committee's September briefing, staff reported not all DSS offices had access to "Outlook", with e-mail capabilities. Central Office Operations has since indicated that all offices now have that service. However, *the committee finds the department is still too reliant on paper rather than electronic communication. While policies are available online, departmental transmittals explaining policy are still mailed to workers, and most management reports generated from EMS are copied and sent to managers.*

Further, *DSS' website, while generally helpful, could provide additional client information and/or make links to other sites more apparent.* For example, the names of medical providers available in the fee-for-service Medicaid program are listed on different sites than DSS' and a link is not provided.

Physical plant. Office conditions vary, although some of that is due to what office space is available in areas accessible to clients, and to the lease agreements that DPW and DSS are able to work out with landlords. However, Central Office Operations should not see its role end with the lease agreement. *Central Office Operations should ensure that certain office features -- like drop-off boxes, standard signage, and a comfortable waiting area for clients – are standard among all offices.*

Further, offices should not have to wait weeks or months to have files awaiting archiving sent to storage, as was noted to committee staff during district office visits. These file boxes take up valuable working space and detract from both the appearance and operations of the office.

Thus, the committee finds considerable deficiencies in the support operations that district office eligibility staff need to conduct their jobs. The committee believes these support functions should not be the responsibility of each office, but should be provided in a coordinated fashion by Central Office Operations.

Therefore, the committee recommends that DSS Central Office Operations take a greater leadership role in providing support services in the district offices. This should include, but not be limited, to:

- **Assuring vendor servicing of the phone systems to upgrade software, maximize capacity of phone message capabilities, standardizing phone**

messages at each office, and tracking phone volume. Further, DSS central operations, through the phone system vendors, should provide better training to district office personnel so they can use the phone system to provide maximum benefit and service.

- **Working with DSS regional administrators and district office managers to ensure that certain service standards are met in each office, including: uniform, good quality signage in English and Spanish; availability of drop boxes for clients to submit materials after hours; comfortable chairs; and good lighting in the waiting areas.**

- **Intervening with other agencies, like the U.S. Postal Service, to ensure that basic services, such as mail pick-up, are provided. Also, other services provided under contract, like the archiving of files, should be provided promptly. Further, if offices lack clerical staff to prune files and box them, some workable solution must be found to address that issue, including:**

    - **a swat team be formed of clerical staff from several offices and the central office to go from office to office filing and boxing for certain days for several weeks until offices are caught up; or**

    - **one day each calendar quarter could be designated (in addition to dedicated processing times) as "file day," where designated staff in an office perform just that function.**

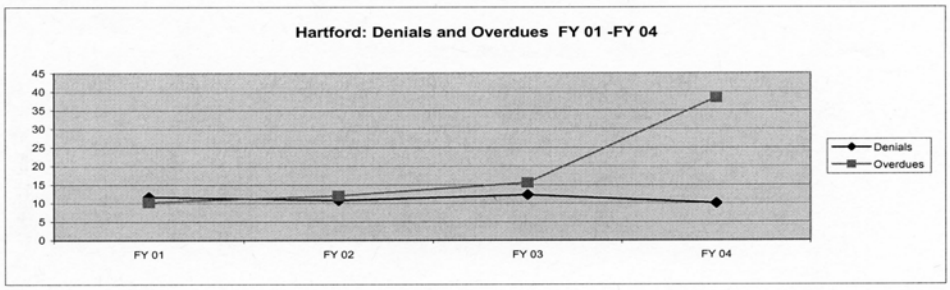
- **Improving internal electronic communication and reporting so there is less reliance on paper. Where possible, the Central Operations Unit should also work with outside institutions, like banks, to increase capabilities for electronic transfer of documents.**

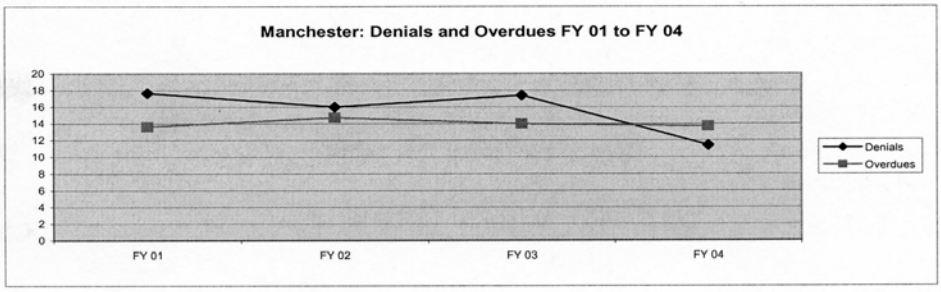
- **Communicating to the district offices exactly what support services are available – like the courier delivery—and how to access those services.**

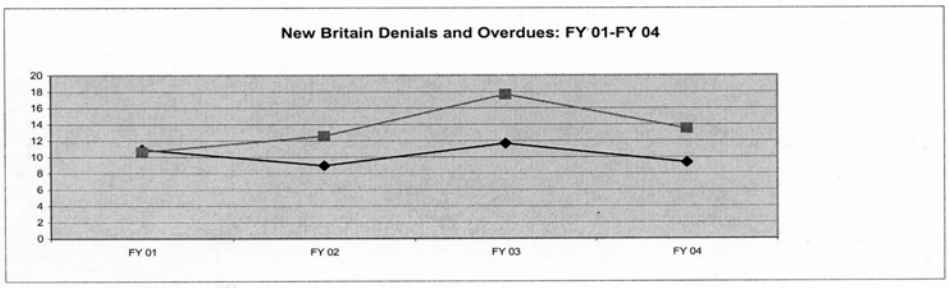
- **Assume a "quality management approach" where Central Office Operations is continuously working with district office managers to improve their facilities and work processes so that core services – determine eligibility, serve clients, issue the appropriate benefits – are provided efficiently.**

Rationale. These types of services and support are crucial to any operation, but especially so when workers are dealing with clients daily. Workers rely on these support systems to function efficiently so that processes and procedures for assisting clients go smoothly. Central Office Operations ought to be more proactive in ensuring this is the case, rather than trouble-shooting only when problems occur. Further, Central Office Operations should not see its role as limited to purchasing or contracting for a service or system. It needs to communicate the service to staff, communicate and/or train them in how to use it, and continuously collaborate with the offices to identify problems, and work on support solutions to constantly improve work processes and outcomes.

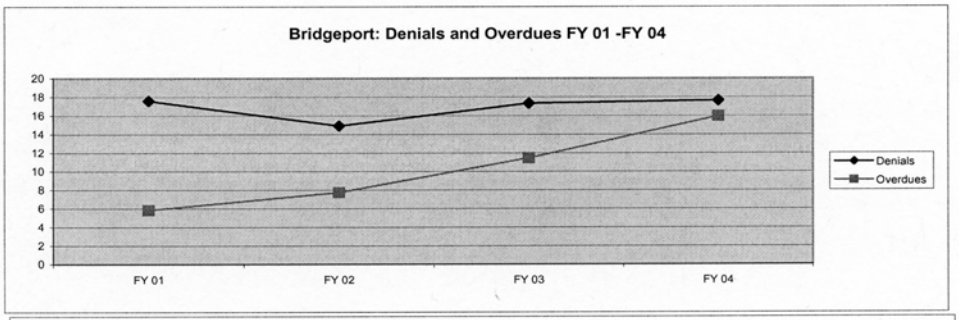
APPENDIX A: Percent of Denials and Overdue by Office
Family Medicaid Applications

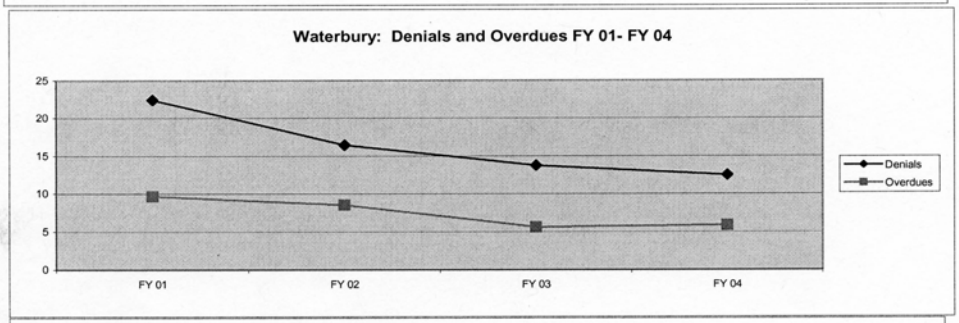


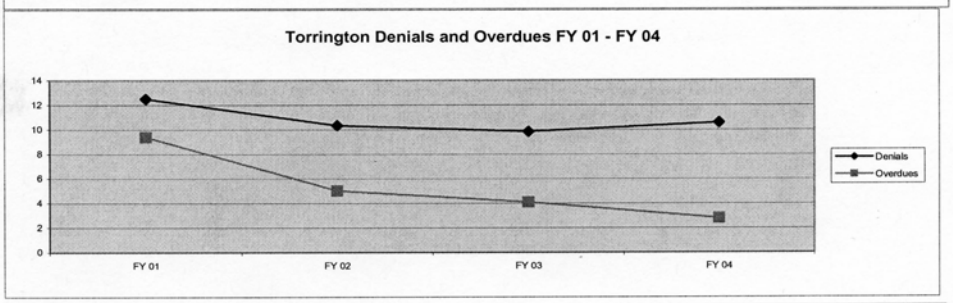


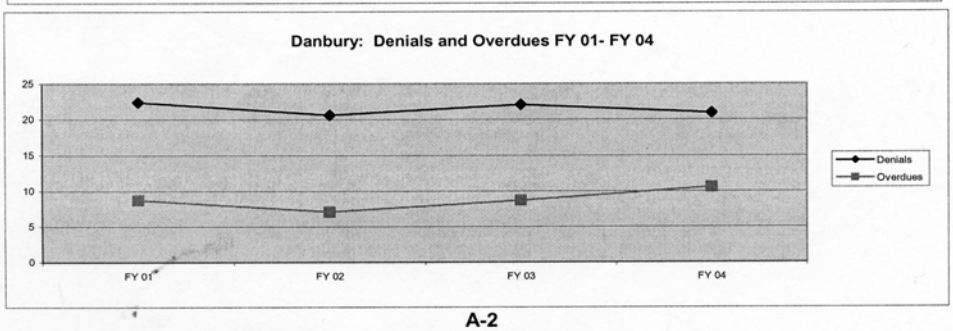


A-1

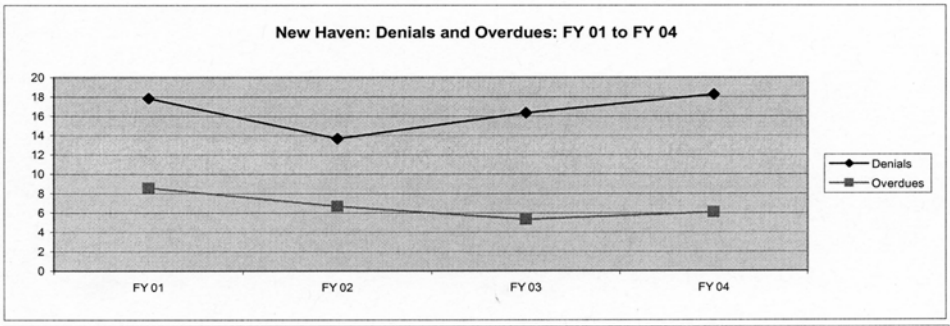

Bridgeport: Denials and Overdues FY 01 -FY 04
20
18
16
14
12
10
8
6
4
2
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues

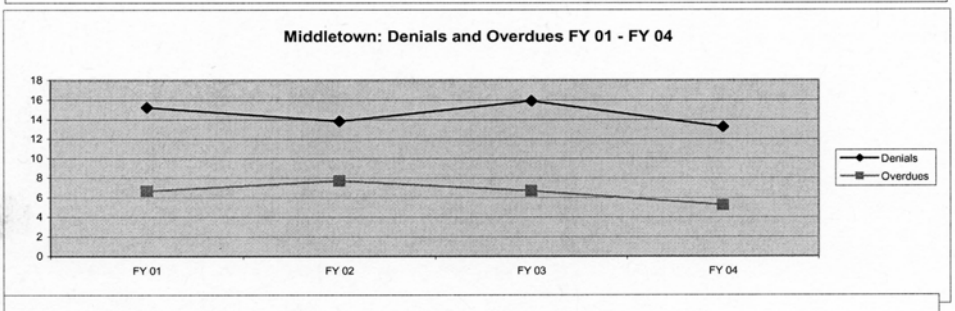

Waterbury: Denials and Overdues FY 01- FY 04
25
20
15
10
5
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues

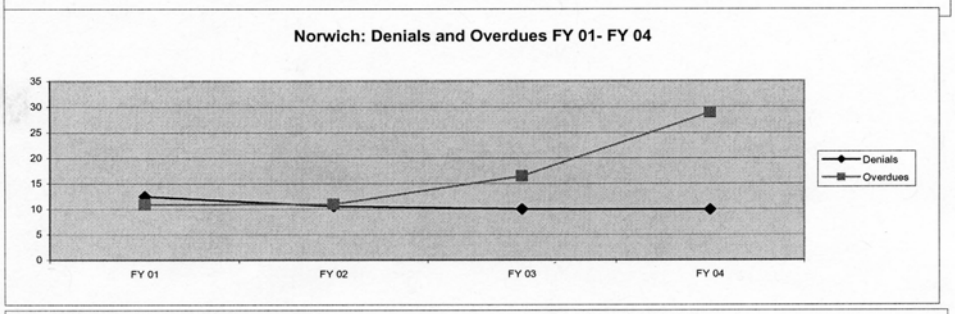

Torrington Denials and Overdues FY 01 - FY 04
14
12
10
8
6
4
2
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues

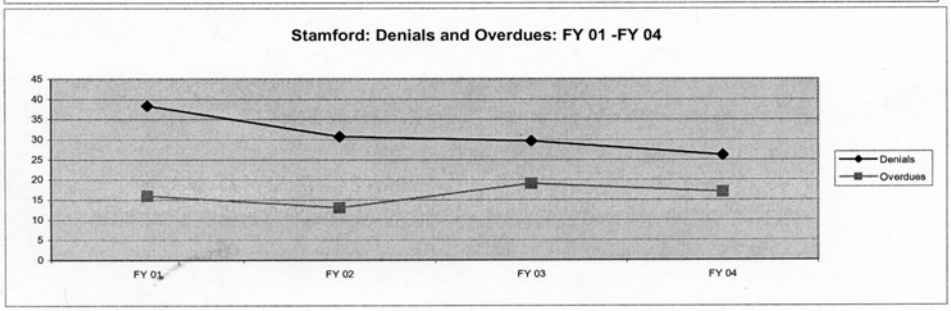

Danbury: Denials and Overdues FY 01- FY 04
25
20
15
10
5
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues

A-2


New Haven: Denials and Overdues: FY 01 to FY 04
20
18
16
14
12
10
8
6
4
2
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues


Middletown: Denials and Overdues FY 01 - FY 04
18
16
14
12
10
8
6
4
2
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues


Norwich: Denials and Overdues FY 01- FY 04
35
30
25
20
15
10
5
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues


Stamford: Denials and Overdues: FY 01 -FY 04
45
40
35
30
25
20
15
10
5
0
FY 01
FY 02
FY 03
FY 04
Denials
Overdues

A-3

APPENDIX B

Committee staff conducted a phone survey of 10 states to collect information on their eligibility management systems, whether those states had online application capabilities, and, if so, how those systems operated, how long they had taken to develop, and the costs. Below is a summary of the survey results.

Pennsylvania

Pennsylvania operates a mainframe eligibility management system originally developed in the 1980s. The system conducts eligibility for all major assistance programs. An online application process (COMPASS) was developed in 2001 as a "front end" component to the mainframe system. COMPASS allows applications for various assistance programs to be submitted via the Internet, although a hardcopy signature page is still required from the applicant. Initial costs to develop the online capacity totaled approximately $500,000, and included state and federal funding and grants. The system was implemented within a year, with the use of in-house staff and an outside consultant.

Texas

Texas is in the beginning stages of developing a new eligibility management system to replace its "SAVERR" mainframe system that is 25 years old. The state legislature originally appropriated $55 million in 1999 to begin developing a new integrated, web-based system "TIERS", with an additional $137 million appropriated in 2001. The new system is being piloted in five offices statewide before full conversion takes place. The state also provides online capacity to screen/evaluate a person's potential eligibility "across multiple health and human service programs" based on information the person enters online. Proposals are currently being sought for a fully automated, web-based application process that would be a component of TIERS.

South Carolina

South Carolina recently implemented a new Medicaid eligibility management system in 2002. The new system replaced one that was 20 years old. Planning for the new system took approximately six years, with the use of Clemson University as an outside consultant. Internal staff was also used for planning, design, and implementation. The system is considered "more automated" than its predecessor, but will not automatically determine an applicant's eligibility as originally designed, due to budget cutbacks. There is no online functionality to the system, including web-based application processing, although a planning committee is beginning to examine this issue.

New Hampshire

In late 1998, New Hampshire implemented a new eligibility management information system replacing its 20-year old mainframe system. The new system's approximate cost was $23 million, and funding came from state and federal sources. Planning took just under three

years, with the use of a consultant and in-house resources. The system allows for automated eligibility determination for various benefit programs, although no web-based application process was part of the original design, due to limited funding. The state does have an online "screening" tool (Wired Wizard) for potential clients to determine what programs they may be eligible for based on information they submit using a web-based questionnaire. The tool can screen potential eligibility for over 60 different programs, and has been in place since 2000.

Vermont

Vermont uses a mainframe eligibility management system developed in 1984. Although the system's underlying software is frequently updated, there are no current plans to implement a new system. The state is developing a web-based screening function to help potential applicants determine which programs they may be eligible for based on information they enter online. The tool will be capable of screening eligibility for all of the state's assistance programs. This process is being developed using in-house resources.

Rhode Island

Rhode Island has mainframe system, an updated adaptation of the Vermont system, which was established in the late 1980s. It performs the eligibility determinations and case maintenance functions for all the major assistance programs. Rhode Island has no plans to upgrade the system, and has no online application capability.

Colorado

Colorado just recently implemented a new eligibility management system for all its major assistance programs. The state started planning for the new system 10 years ago, and the development of the system took three to four years. The new system replaced a 30-year-old Legacy system that really did not determine eligibility, but served more as a program database. The new system cost more than $100 million dollars, but reports in the Denver newspapers indicate the first months of system operations have not been smooth, with many people not receiving their assistance. The new system has no online application capabilities at this time.

Maine

In 2002, Maine began using a new web-based Oracle system known as ACES (Automated Client Eligibility System). It replaced a 30-year-old mainframe Legacy system, which like Colorado's, did not really determine eligibility and benefits, but functioned more as a database. Maine spent about $22-$23 million on its new system, and used a consultant for project development. The consultant continues to be paid to providing training and other ongoing services. The project received 50% matching federal funds; according to Maine officials, the

state had missed deadlines for the higher 90% federal reimbursement. The transition to the new system caused problems because the state had to enter data from the old system and paper files. During that period, workers were not as carefully determining client eligibility and the state's error rate went up. The system has no online enrollment capabilities at this time.

California

California operates a 30-year-old mainframe system that is used by 58 counties or local government agencies to determine eligibility for all assistance programs, including about 6.5 million Medicaid clients monthly. A very preliminary proposal was put forth by a statewide group appointed by Governor Schwarzenegger to examine overall state government performance, but nothing has reached the planning and development or financing stage. California does give online application capabilities to "certified application assistants" primarily workers at community-based agencies. These assistants can then help clients complete and transmit their applications electronically. Health-e-App, as the program is called, began as a pilot in the San Diego area in 2001, and went statewide in 2002. Only applications for Medicaid for children are currently accepted electronically, but there are plans to expand that. The Health-e-App system cost between $1-$2 million to develop, and the application assistants are paid $50 for each completed application received. Some federal funding was available for system development, although not as much as initially expected. Some private funding was obtained to match state monies.

Washington

Washington has a relatively online system that was begun in 1997. It uses an online blended application and replaced an old system that was primarily a database, and relied on a lot of manual calculations to determine eligibility. The new system provides online application functions, but the applications do not yet interface with ACES, the eligibility management system. On line applications account for only about 5 percent of applications, which state officials find disappointing, but believe is adequate to continue the capability.